Responsibilities for the Global Health Crisis

DPhil thesis

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Abstract

This thesis aims to provide a framework for analyzing the moral responsibilities of global agents in what I call the Global Health Crisis (GHC), with special attention devoted to the moral responsibilities of pharmaceutical companies. The main contribution of this thesis is to provide a general account of the moral responsibilities of different global players, mapping the different kinds of duties they have, their content and force, and their relation to the responsibilities of other relevant actors in the GHC. I also apply this account to current debates surrounding the need for reforms to the international legal rules addressing the GHC, notably the TRIPs regime. In doing so, this thesis will discuss the allocation of responsibilities for the GHC among different global players, such as state and non-state actors, the latter including pharmaceutical companies. In order to investigate the allocation of duties, I will first analyze the object of such allocation which constitutes the object of the current GHC (Part A); then the agents responsible for addressing this crisis (Part B); and finally, existing institutional alternatives to reform the international legal rules addressing the GHC, such as the TRIPs regime (Part C).

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Table of Abbreviations

CPR – Civil and Political Rights
DNDi – Drugs for Neglected Diseases Initiative
ECOSOC – Economic and Social Council
ESCR – Economic, Social and Cultural Rights
EU – European Union
FDA – Food and Drug Administration
GCJ – Global Commutative Justice
GDP – Gross Domestic Product
GHC – Global Health Crisis
GSK – GlaxoSmithKline
HIF – Health Impact Fund
HIV/AIDS – Human immunodeficiency virus infection / acquired immunodeficiency syndrome
HKI - Helen Keller International
HRC – Human Rights Council
IAVI – International AIDS Vaccine Initiate
ICCPR – International Covenant of Civil and Political Rights
ICESCR – International Convenant on Economic, Social and Cultural Rights
ICRC - International Committee of the Red Cross
ICTSD - International Centre for Trade and Sustainable Development
ICTSD – International Centre for Trade and Sustainable Development
IFPMA - International Federation of Pharmaceutical Manufactures & Associations
IGPA - International Generic Pharmaceutical Alliance
IMF – International Monetary Fund
MMV - Medicines for Malaria Venture
MSF – Médecins Sans Frontières
NGO – Non-governmental organization
OHCHR – Office of the High Commissioner for Human Rights

PDP – Product Development Partnerships

PhRMA – Pharmaceutical Research and Manufacturers of America

R&D – Research and Development

TB – Tuberculosis

TRIPs – Trade-Related Aspects of Intellectual Property Rights

UAEM – Universities Allied for Essential Medicines

UDHR – Universal Declaration of Human Rights

UMIC – upper-middle-income country

UN – United Nations

UNCTAD – United Nations Conference on Trade and Development

UNDP – United Nations Development Programme

UNFPA – United Nations Population Fund

UNICEF – United Nations Children's Fund

USA – United States of America

USTR – United States Trade Representatives

WHO – World Health Organization

WIPO – World Intellectual Property Organization

WTO – World Trade Organization

WWII – World War II

Table of Statues

UN Bill of Rights

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UN ESCR

OHCHR

WTO

INCSTD and UNCTAD

WHO

USA

Introduction

This thesis aims to provide a framework for analyzing the moral responsibilities of the global players in what I call the Global Health Crisis (henceforth GHC), with special attention devoted to the moral responsibilities of pharmaceutical companies. I defend the following claim: while all global players share certain responsibilities in remediating the negative effects of the GHC, different degrees of responsibility apply to different players according to their relation to the GHC and to those affected by it; in this regard, pharmaceutical firms have certain responsibilities that apply specifically to them as private owners of relevant medical knowledge.

An argument about responsibility for a common problem must first say something about the problem itself. What is the GHC and what kind of moral and legal problems does it present? I address this question here in the Introduction. In order to answer this question, I first briefly explain what I mean by 'GHC'. Then, by providing some figures about its adverse effects on people's health, I further discuss how these negative impacts are perpetuated and exacerbated by the current system of international law, notably, the international intellectual property regime. In doing so, I make explicit the factual premises of the normative analysis offered in this thesis, as well as their sources. In the last section of this introduction, I briefly outline each chapter of the thesis and their respective relation to the problematic introduced here.

1. The Global Health Crisis

This thesis relies on the factual premise that the GHC is fundamentally a crisis of research and development (R&D) in the area that global health experts call 'neglected diseases'[1]. It is an issue driven by a lack of research and the inability of those most afflicted to use developed and patented medicines.[2] This factual premise is widely accepted by scholars in the area and grounded in different expert analyses of the neglected diseases problem. There are three main international organisations specialized in dealing with the neglected diseases problem, namely the World Health Organization (WHO), the World Trade Organization (WTO), and the World Intellectual Property Organization (WIPO). Recently, all three published a joint report in which they analyze the neglected diseases problem on a global scale, and discuss the intellectual property and public health policy questions that the problem poses. The WHO, the WTO, and the WIPO all point to the lack of R&D in the area of neglected diseases as a major roadblock to improving global health conditions. They state:

> The unavailability of medical technologies to effectively address neglected diseases is one of the major problems associated with tackling this human health tragedy. The situation has been characterized by a chronic lack of investment in R&D to find effective treatments for neglected diseases. The innovation effort is starkly disproportionate to the public health challenge posed by such diseases. Since the diseases are concentrated in poor countries, and

[1] The concept of neglected diseases is uncontroversial and widely accepted, as further discussed below.

[2] I will use the terms medicine, medical treatment, and medication interchangeably, referring to medical technologies/innovations in general, including medical goods, services, and processes, such as drugs and vaccines, as well as medical procedures, treatments and devices.

since poor people are affected the most, it is not just the diseases that are neglected; rather the problem is one of neglecting patients who die of these diseases.[3]

This factual R&D imbalance as related to neglected diseases is agreed upon not only among international institutions, but also among global public health experts. Recently, a team of renowned experts in the field published a report in *The Lancet* – a reference journal in the field of medicine – in which they concluded that, as per their empirical findings, minor progress has been made with respect to discoveries and developments addressing neglected diseases, but the chronic imbalance persists. As they put it: 'Some progress has been made, but these advancements have not in large part redressed the R&D imbalance, reported more than a decade ago, in truly new therapeutic products for neglected diseases'.[4]

The GHC, as I term it, refers precisely to this ongoing situation in which a deplorably large number of people, predominantly in poor countries, are dying due to neglected diseases and the fact that solutions to this problem are impeded by a number of legal and knowledge-related barriers, in particular the rules of the current international intellectual property regime as expressed by the TRIPs system[5]. The remediation of the

[3] WHO/WTO/WIPO, *Promoting Access to Medical Technologies and Innovation – intersections between public health, intellectual property and trade*, 2013, p.116

[4] Pedrique et al, 'The drug and vaccine landscape for neglected diseases (2000-11): a systematic assessment', in *Lancet Global Health*, Early Online Publication, 24Oct2013, p.e376, http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(13)70078-0/fulltext

[5] The WTO's agreement on *Trade-Related Aspects of Intellectual Property Rights* (TRIPs) negotiated between 1986 and 1994, during the Uruguay Round, introduced intellectual property rules into the multilateral trading system. See: http://www.wto.org/english/thewto_e/whatis_e/tif_e/agrm7_e.htm

GHC is complex and will require R&D among other things, such as the competent delivery of appropriate health care goods and services, as I address later. However, before any good and service can be created and delivered, there must first be medical knowledge which is discovered and researched, and then developed into suitable medical technologies. It is in this sense that lack of access to medical knowledge (i.e. research and discovery) and lack of access to medical technologies (i.e. development of medicines) are both primary issues: without proper incentives and support for R&D, the death toll associated with neglected diseases will not and cannot decrease. It is on these empirical premises that I base this thesis.

I also rely on the widely accepted idea of neglected diseases. The general concept of neglected diseases is fairly uncontroversial, although the precise illnesses that different authorities include in their numerous lists may vary slightly according to their methodology and purposes. Yet, it is generally accepted that neglected diseases, as Paul Hunt – former UN Special Rapporteur for the Right to Health - puts it, are 'those diseases understood to be primarily affecting people living in poverty in developing countries, in particular in rural areas.'[6] Likewise, as defined by the experts in their *Lancet* publication: 'Neglected diseases, understood broadly as diseases affecting populations in mainly low-income countries, are a leading cause of mortality, chronic disability, and poverty'[7]. The joint WHO/WTO/WIPO report provides the most thorough definition:

> [Neglected diseases are] diseases that disproportionately affect poor people in developing countries as the market mechanisms, such as intellectual property

[6] Hunt, *Neglected Diseases – A Human Rights Analysis*, WHO, *Special Topics in Social, Economic and Behavioral Research Report Series*, No. 6, 2007, p.1

[7] Pedrique et al, 2013. p.e371

right do not work in this case. A key factor is the limited purchasing power of both governments and patients in the countries where such diseases predominate; unlike for other diseases targeted at more affluent markets.[8]

The GHC therefore comes about as a result of the unavailability of medicine, which is itself largely due to the lack of R&D. This unavailability of medicine is two-fold: (i) it is first an unavailability of *access to medical knowledge* on neglected diseases, and (ii) it is also an unavailability of *access to medicines that have been developed* to treat neglected diseases. These two unavailabilities result from market failures within the TRIPs regime: the first a failure in the market for *discovery* of medical knowledge relevant for neglected diseases, and the other a failure in the subsequent market for the *development* of such medical knowledge into adequate medicines. These two market failures have catastrophic effects when combined. The GHC emerges thus as a dual problem of medical knowledge *and* medical technologies for treating neglected diseases, both due to a lack of research as well as development. But before discussing how the TRIPs regime produces these two market failures, let us first examine their catastrophic effects.

2. The catastrophic effects of lack of access to medical knowledge and lack of access to medicines for neglected diseases

It is said that 1.4 billion people worldwide are affected by so-called extremely neglected tropical diseases,[9] for which there are very few discoveries or ongoing research and no

[8] WHO/WTO/WIPO, 2013, p.115

[9] Bill and Melinda Gates Foundation, *Private and Public Partners Unite to Combat 10 Neglected Tropical Diseases by 2020*, 2012

currently available adequate treatments. In other words, at least 1.4 billion people are affected by lack of access to medical knowledge, by which I mean access to medical discovery, research and innovation, on neglected diseases and especially those concentrated in the tropical zone. It is not possible to determine with certitude whether 1.4 billion is the total amount of people worldwide affected by lack of medical knowledge on neglected diseases *per se*, as neglected tropical diseases are a subset of neglected diseases. Neither is it possible to precisely ascertain which neglected tropical diseases have no existing treatment at all, and which ones have some treatment in phases of development and clinical trials. Nevertheless, in light of the above, it is sound to assert that at least 1.4 billion people worldwide are affected by lack of access to medical knowledge on neglected diseases, whether tropical or otherwise.

It is also said that 2 billion people lack access to essential medicines.[10] Medicines considered 'essential' refer to medicines for which there are both medical knowledge and developed treatments available. Yet, these medicines are not accessible for a number of different reasons: for example, medical knowledge might be kept secret under patent protections; or, existing medical treatments might be too expensive for certain afflicted populations or inadequately formulated for certain patients with specific requirements. The WHO emphasizes that some 2 billion people are affected by a lack of medicines listed in its catalog as 'essential'[11]. However, this figure in itself is not sufficient to arrive at any conclusions about R&D on neglected diseases, as the WHO's list goes beyond medicines for neglected diseases and includes various other diseases that are not generally considered 'neglected'. In fact, the WHO's list of essential

[10] UN.Doc.A/HRC/11/12, Report of the Special Rapporteur on the Right to Health, Grover, 2009, para.13; WHO, *WHO Medicines Strategy: Countries at the Core 2004-2007*, 2004

[11] See: http://apps.who.int/medicinedocs/en/d/Js6160e/9.html

medicines focuses on the broader category of 'infectious diseases affecting poor countries', which may not necessarily correlate with the WHO's list of neglected diseases. Therefore, using data on lack of access to *essential* medicines has certain limitations when it comes to clarifying matters of R&D on neglected diseases. As the *Lancet* publication explains it: 'Use of inclusion in the WHO Essential Medicines List as a proxy metric for medical innovation has its limits because the list favors infectious diseases affecting, and low-cost products for, low-income countries.'[12] Nevertheless, despite not being the most adequate of sources for information regarding R&D on neglected diseases, the WHO Essential Medicine List allows us to make the following statement: at least 2 billion people worldwide are affected by lack of access to medicines that are *available* (meaning for which some treatment exists), but are not *accessible* (for a number of reason, as I set out below).

These figures on the lack of access to medical knowledge and the lack of access to medicine are not sufficient in themselves to show the precise impact of each component of the GHC. However, the figures are sufficient to show that the GHC is a moral catastrophe in need of urgent remediation, given the number of its death toll[13].

These catastrophic consequences have been exacerbated since 1994, when the TRIPs system came into effect, as the latter worsened the already malign effects of historical severe poverty and ill-health in developing and least-developed countries (defined as former colonies of developed countries). Both lack of access to medical knowledge and lack of access to medical technologies are related to the TRIPs. It is generally argued

[12] Pedrique et al, 2013. p.e376

[13] I explain why the GHC qualifies as a catastrophe in chapter 4.

that the TRIPs have magnified the harmful consequences of existing poverty in an unprecedented manner, in the same way that globalization (i.e. the current global economic order, shaped by relatively recent legal instruments such as TRIPs) has considerably aggravated 'global poverty' -- where 'global poverty' is generally understood as the world population living under a severe deprivation of basic human needs, such as adequate nutrition, safe drinking water, basic sanitation, adequate shelter, literacy, and basic health care.[14] In this thesis I will focus on one particular aspect of the current global economic order, namely the TRIPs regime, and I will discuss its implications on one particular aspect of 'global poverty', namely the severe deprivation of basic health needs amounting to what I am calling the GHC. As I rely in chapters 2 and 5 of this thesis on the widely accepted argument set out above, that is, that the TRIPs regime has exacerbated the adverse effects of global poverty and neglected diseases, it seems relevant to further analyze this claim by comparing the pre-TRIPs situation (before 1994) with the status quo (after 1994), as regards the object of the GHC, namely R&D imbalance with respect to neglected diseases.

As mentioned above, the neglected diseases R&D imbalance has been 'chronic'.[15] This imbalance has remained consistent over the last few decades in spite of great scientific progress in medical sciences and not insignificant advancements for certain neglected diseases (such as HIV, TB and malaria). In order to analyse the impact of the TRIPs regime on this imbalance, I will compare the situation before 1994 with that of after 1994.

[14] See Pogge, *World Poverty and Human Rights*, 2008, where he fully explains his argument on how the current global economic order engenders global poverty. Pogge states that 'some 2.5 billion human beings live in severe poverty, deprived of such essentials as adequate nutrition, safe drinking water, basic sanitation, adequate shelter, literacy, and basic health care. One third of all human deaths are from poverty-related causes: 18 million annually, including over 10 million children under five.' (p.13)

[15] WHO/WTO/WIPO, 2013, p.116

According to the report published in *The Lancet*, from 1975 to 1999 (therefore mainly pre-TRIPs), 1,393 new therapeutic products were developed. Of these, only 16 (1.1%) were for neglected diseases, while such diseases accounted for 12% of the global burden of diseases[16]. In the subsequent period from 2000 to 2011, of the 850 new therapeutic products registered, 37 (4%) were for neglected diseases, comprising of 29 products with a new formulation and 8 vaccines or biological products. Of the 336 new chemical entities approved during this study period, only 4 (1%) of them were for treatment of neglected diseases, comprising of 3 for malaria and one for diarrhoeal disease[17]. The report concludes by saying:

> Our findings show a persistent deficiency in product development for neglected diseases, although in the past 12 years positive advances have been seen for neglected-disease treatments, based mainly on the number of newly approved drug reformulations, repurposed products, and vaccines, as well as the number of ongoing clinical trials, especially for vaccines. Nevertheless, a major R&D gap remains in new chemical entities for neglected diseases, both in terms of new approvals and ongoing clinical development as shown by only 1% of existing clinical trials focused on this area. Malaria, tuberculosis, and diarrheal diseases remain the main focus of product-development research, with little focus on other neglected diseases. Providing the required treatments to control and then eliminate neglected

[16] Pedrique et al, 2013. p.e376

[17] Ibid, p.e371

diseases is a crucial concern and will require investment efforts into R&D for neglected diseases on all fronts.[18]

The conclusions of the report are clear: despite some progress in the discovery and development of medicines for neglected diseases, the R&D imbalance persists. What is more, what little progress there has been is not actually due to new research or discovery; rather, it is due to the re-engineering of existing treatments. As the report further puts it: 'of the 29 new products, few are truly innovative: most are based on the repurposing of existing treatments, namely reformulations, new indications, or fixed-dose combinations.'[19]

Therefore, in both the pre-TRIPs period and the status quo, the R&D imbalance on neglected diseases appears to have remained essentially the same, with modest progress on some fronts thanks to incentives and investments towards the fight against certain neglected diseases such as HIV, tuberculosis and malaria (the so-called 'big three'). In this manner, the historical imbalance against neglected diseases persists under the TRIPs regime. And, as I will further explain below, the existing R&D cycle nurtured by the TRIPs system will continue to perpetuate this imbalance, unless structural reforms are implemented in order to remediate specific institutional failures in the discovery and development phases of the R&D cycle[20].

[18] Ibid, p.e378

[19] Ibid, p.e377

[20] I discuss various existing and proposed remedies to the different aspects of the GHC in chapter 5.

The rules of the TRIPs system are an important part of the GHC's dual access problems. Regarding the lack of access to medical knowledge, the TRIPs regime creates considerable difficulties in correcting the R&D imbalance related to neglected diseases, as explained above. As for the lack of access to medicine, the TRIPs rules are a major impediment to the provision of cheap generic medicines and the development of adequate formulation for the specific health needs of poor populations. It is particularly with regard to the latter that the TRIPs is a clear step backwards. The TRIPs introduced, and continues to impose, obstacles against the development of affordable and adequate medicines for poor populations, obstacles which did not exist before the adoption of the TRIPs Agreement in 1994. These obstacles are legal barriers established by the new intellectual property laws passed under the TRIPs Agreement. It has been argued that the TRIPs regime (or at least its effects) is unjust because it has caused the poorest populations of the world to be even worse off[21]. Before 1994, the poor had better access to their basic health needs. As Pogge puts it:

> Before the TRIPs Agreement was adopted, most of the less developed countries had weak intellectual property protections or none at all, which enabled them to produce or import cheap generic versions of advanced medicines that were patented and thus much more expensive in the affluent countries. Relative to the Pre-TRIPs, status-quo thus impose a serious loss on the poorer three quarters of the human population by pricing out of their reach new medicines that otherwise they could have obtained at generic prices either through their own efforts or with the help of friends, relatives, NGOs, or governmental and intergovernmental agencies.

[21] This argument is set forth in Hollis and Pogge, *Health Impact Fund – Making New Medicines Accessible for All*, 2008, p.53

As I discuss in chapter 5, the TRIPs further deteriorated the health of the world's poorest populations inasmuch as these people must now pay much higher prices for certain medicines, without which they cannot live a minimally decent life. Surely, poverty has always existed. However, by comparing the pre-TRIPs situation with the current one, evidence shows that before 1994, the poor could more easily (meaning, with fewer legal and economic restrictions) obtain new medicines at generic prices[22]. For example, the poorest countries, even if they did not have any producing capacity to manufacture the generic versions themselves, could import these much-needed generic versions from developing countries such as Brazil, India or Thailand, whose generic drug industries by 1994 had fairly good producing capacities.

The current TRIPs regime does two things: (i) it makes effective medicines unaffordable – and thus inaccessible to most patients in poor countries – until the end of the patent term; and (ii) it gives no adequate market incentives for medical innovators (such as pharmaceutical companies) to invest their costly R&D efforts on formulations appropriate for the specific material and environmental conditions of the poorest populations. For example, tropical weather and remote rural areas may require changes in the original formulation, or specific conditions of delivery, transport and storage to guarantee the effectiveness of the medicine. It is in this sense that the current patent protections over medical R&D *exacerbate* or *aggravate* the neglected status of certain diseases for large parts of the global population. I return to these issues in chapters 2 and 5.

[22] Ibid.

The GHC precisely refers to this situation in which a catastrophic number of people are dying of neglected diseases. The complex problems of *discovery* of medical knowledge and *development* of *affordable and adequate* medicine are significant elements of the crisis – and the GHC cannot be solved without changes in these two (TRIPs-related) issues[23]. This thesis argues that there is a stringent moral duty to remediate[24] the GHC, based on the moral consequences flowing from the considerable number of deaths caused by neglected diseases. The remediation of the GHC is complex, and it will require R&D along with other things, such as competent delivery of affordable and adequate health care goods and services. Nevertheless, researching and discovering medical knowledge and then developing it into affordable and adequate medical technologies, are the first steps in tackling this R&D imbalance. In the following section, I further analyze how the internal logic of the TRIPs system contributes to these failures in the discovery of medical knowledge and the development of medicine.

3. The TRIPs and the dual problem of lack of access to medical knowledge and lack of access to medicine for neglected diseases

The TRIPs regime incentivizes the innovation of scientific knowledge, which includes medical knowledge, through the expectation of high yields and profits in compensation for earlier costly R&D investments. These are the two purposes of intellectual property rights: incentive and compensation[25]. The TRIPs regime regulates both incentives and

[23] See chapter 5 for a discussion of both existing and proposed solutions to the dual problem of neglected diseases.

[24] See chapter 2.

[25] See Risse, 'Is there a Human Right to Essential Pharmaceuticals?', in Millum and Emanuel, *Global Justice and Bioethics*, 2012, p.67

compensation, as premises and constraints of the system. While the incentives provided by the TRIPs system foster innovations of scientific knowledge, compensation allows a reasonable recoup of previous R&D costs[26]. The innovation or R&D process is explained as a cycle with three main phases that mutually nurture one another: Discovery, Development, and Delivery. This is known as the '3-D cycle'[27]. The first phase of Discovery comprises the long process of basic medical research. The second phase of Development comprises the pre-clinical and clinical trials as well as further developments of the product and its production process, in the hope of achieving successful market approval and manufacture of the treatment. Finally, there is the third phase of Delivery, when the products are distributed and actually reach the patients (which I shall define as consumers of medical treatments).

Although the TRIPs rationale impacts more directly the first two phases of discovery and development, it is dependent on and informed by the third phase of delivery, since it is the market demand from the consumers of medical products (i.e. patients) that incentivizes and shapes the discovery of new medical formulations carried out by medical researchers. So, what is scientifically investigated and later manufactured is solely determined, within the TRIPs rationale, by what the market demands[28]. Medical research institutions (such as pharmaceutical companies) are the original owners of the medical knowledge they discover and develop, and the TRIPs system protects their private ownership[29]. Medical research institutions, such as pharmaceutical firms, are

[26] Ibid.

[27] WHO, *Public Health Innovation and Intellectual Property Rights*, Report of the Commission on Intellectual Property Rights, Innovation and Public Health, 2006, pp.22-3

[28] WHO/WTO/WIPO, 2013, p.108

[29] I will put forth this argument in chapter 4.

therefore fully involved in the first and second phases of innovation/R&D. After entry of their medical product into the market, its actual delivery to the patients will depend more directly on other players along the supply chain, such as suppliers, public health agents, medical doctors, nurses, and so on, who will more directly deliver and administer the treatment to the patient. In spite of not being directly involved in the third phase of delivery, it is the patients' demand curve that will shape what will receive priority of R&D efforts[30].

The R&D cycle is self-sustaining for developed countries and large markets. But it is not so for low-income countries with small markets[31]. In the case of medical technology for neglected diseases, the 3-D cycle rationale fails. Because neglected diseases are 'those diseases understood to be primarily affecting people living in poverty in developing countries, in particular in rural areas'[32], they afflict mainly or exclusively poor populations with little or no purchase power. As a consequence, medical researchers lack the regular market incentives to invest their R&D efforts for discovering and developing medical products addressing the medical conditions of poor populations. This is so because these people cannot and will not be able to afford the final product's price. Medical scientists and their research institutions (such as pharmaceutical firms) have therefore no market incentive to initiate investigations on neglected diseases. Medical R&D is a particularly lengthy and costly process, as most of the investigations initiated end up failing along the way and thereby never succeed in being manufactured into a marketable product. Because of this, under the current TRIPs regime, R&D efforts are

[30] WHO/WTO/WIPO, 2013, p.108

[31] Ibid, p.105, 109

[32] Hunt, 2007, p.1

incentivized and compensated by patent-protected mark-ups. Given that medical R&D is currently, under the TRIPs regime, driven primarily by market demand rather than global health needs, and given that there is no expectation of high sales and large mark-ups for medical innovation on neglected diseases, diseases afflicting the poorest populations remain 'neglected' by the medical research community.

The scientific community does not neglect all the diseases categorized under the label 'neglected' in the same way, however. There are the so-called Type 3 diseases, referring to diseases that are the most neglected because they affect predominantly or exclusively in poor countries[33]. The WHO currently lists 17 of these most neglected diseases, or, to be more precise, 'neglected tropical diseases', as they have been recently called since they are geographically clustered around the tropical zone[34]. These 17 medical conditions all fall under the Type 3 category. They are most neglected of all, because the neglect stems from the very first phase of discovery: there is no market incentive at all to initiate investigations focusing on Type 3 diseases. As a result, there is no adequate medical knowledge and thus no appropriate medical treatment for them.

According to Hunt's definition, 'Type III diseases - often termed very neglected diseases - are those that overwhelmingly or exclusively occur in developing countries, such as river blindness and sleeping sickness'. (UN.Doc.E/CN.4/2003/58, Hunt, Report of the Special Rapporteur to the Commission on Human Rights, 13Feb2003, para.74)

According to the WHO definition: 'Type III: incident almost exclusively in poor countries. These are known as extremely neglected diseases, e.g. African sleeping sickness and river blindness. R&D in rich countries is almost non-existent and new treatment developments are usually fortuitous or accidental discoveries'. Available at: http://www.who.int/trade/glossary/story079/en/

[34] The list of 17 neglected tropical diseases is: Dengue, rabies, blinding trachoma, Buruli ulcer, endemic treponematoses (yaws), leprosy (Hansen disease), Chagas disease, human African trypanosomiasis (sleeping sickness), leishmaniasis, cysticercosis, dracunculiasis (guinea-worm disease), echinococcosis, foodborne trematode infections, lymphatic filariasis, onchocerciasis (river blindness), schistosomiasis (bilharziasis), soil-transmitted helminthiases (intestinal worms). WHO, *Accelerating Work to Overcome the Global Impact of Neglected Diseases – A Roadmap for Implementation*, 2012, p.1.

See also London Declaration on Neglected Tropical Disease, 30Jan2012; and WHO.Doc.A66/20, *Neglected Tropical Diseases – Prevention, Control, Elimination, and Eradication – Report by the Secretariat*, 15 March 2013.

There are certain other neglected diseases, on the other hand, that afflict not only the poorest populations of the poor countries, but also certain populations of developed countries. These are the so-called Type 2 diseases[35]. They are in a slightly better situation in comparison to Type 3's: there are certain incentives and investments for the discovery of treatments for Type 2 diseases, and therefore some treatments have actually been developed and are technically available. In this manner, whereas Type 3 diseases are neglected since the very first phase of discovery, Type 2 diseases are not as badly neglected – certain treatments for Type 2 diseases have successfully passed the first phase of discovery and reached the second phase of development or, in some cases, even the third phase of actual delivery to patients. Examples of Type 2 diseases with treatments available include HIV, tuberculosis (TB), and malaria. There are many anti-retrovirals and many first-line anti-TB drugs that have successfully reached the third phase of delivery. However, certain kinds of anti-retrovirals that interact with anti-TB drugs, and certain second-line anti-TB drugs (meaning, those that address the sort of TB that has created resistance to first-line anti-TB drugs), and also certain antimalarials are examples of medicines for Type 2 disease which have successfully passed the first phase of innovation, but are now between the second and third phases of development and delivery. In actuality, these three Type 2 neglected diseases, namely HIV, TB and malaria, are known as the 'big three', since they are not strictly speaking 'neglected' anymore: they have received significant financial incentives and investments from the international community for both the discovery and the development of treatments.

[35] 'According to Hunt's definition, 'Type II diseases - often termed neglected diseases - occur in both rich and poor countries, but with a substantial proportion of the cases in the poor countries, e.g. HIV/AIDS and tuberculosis' (UN.Doc.E/CN.4/2003/58, 13Feb2003, para.73).

According to the WHO definition: 'Type II: incident in rich and poor countries, but with a much greater incidence in poor countries, such as HIV/AIDS and TB. R&D incentives exist in the rich countries, but the level of spending is very low compared to global disease burden'. Available at: http://www.who.int/trade/glossary/story079/en/

There are, nevertheless, two main problems related to Type 2 diseases: in spite of being technically available, the treatments that have been discovered and developed are either unaffordable or inadequate for the majority of the afflicted populations in poor countries. In the case of non-affordable treatments, the benefit of having a developed treatment is negated because such treatment is priced beyond the reach of its poor patients. In the case of inadequate treatments, the benefit of having a developed treatment is negated because the treatment has been formulated for the specific conditions of patients in developed countries, and such formulation may not be adequate for the specific conditions in the developing and least-developing countries[36]. Both problems of affordability and adequacy can be explained in relation to the TRIPs system[37]. Medical treatment is often highly priced so that innovators can recoup the investment costs they incurred during the R&D process. Also, medicines are highly priced because they primarily target those better-off patients in developed nations, which also explain why these same formulations are often inadequate for the specific medical conditions of the poorest populations in developing countries.

But even when medical treatments for Type 2 diseases are actually affordable and adequate for the needs of the poorest populations, there often comes an extra obstacle in the shape of the third phase of delivery of the medicine. Poor countries often lack the basic infrastructure for primary health care and basic sanitation, including trained

[36] For example, the different climate and environmental conditions of the tropical zone might demand specific forms of conservation and administration of the medicine, which, if not observed, may make the medicine inadequate or even poisoning. Also, different patient populations might demand different formulations or different dosages: take, for example, the case of an anti-retroviral. If, for example, the afflicted population in a poor country is mainly children, the elderly, and undernourished adults, and the original formulation was designed for the average adult population of developed countries, there might be a need for a reformulation.

[37] On 'IP-related determinants of access', see: WHO/WTO/WIPO, 2013, pp.171-91

medical staff and even proper means of transportation, which prevents medication from successfully reaching the patients, particularly those in remote rural areas. Altogether, these additional barriers further aggravate the patients' difficulties in having access to the developed treatment. These additional barriers are often referred to as the 'last-mile problem'.[38] As the name suggests, this is an end-of-the-line problem and, as such, is only remotely linked to the TRIPs and the innovation/R&D phases of discovery and development discussed above.

The TRIPs-related questions concerning medical knowledge and innovation are essentially related to the initial phases of discovery and development, including the problems of affordability and adequacy of the developed treatment. The questions concerning the distribution of health care goods and services, including the last-mile problem, are related to the third phase of delivery, and fall outside the sphere of direct influence of the TRIPs. Surely, problems of delivery of health care goods and services are serious; and they add much complexity to the poverty-related global health issues, such as the GHC. Nevertheless, the questions concerning discovery and development of medical knowledge/innovation, and the questions concerning the delivery of health care treatments, are of different nature and scopes, and involve different agents and different forms of implementation. They are still fundamental for resolving the GHC, even if they are not the only relevant factor. In this thesis, I engage primarily with discussions related to the questions of discovery and development of medical knowledge/innovation at the international level. As my interest lies in analysing the fundamental issues pertaining to the global neglected diseases problematic, I will not deal with questions concerning the

[38] As Hollis and Pogge put it: 'The last-mile problem refers to the challenge of ensuring that available medicines of good quality are (1) accessible to and (2) correctly used by the people who need them' (2008, p.71).

delivery and domestic distribution of health care resources and facilities. In particular, I will focus on one of two aspects of the dual access problem set out earlier: namely, the lack of access to medical knowledge (research/discovery) on neglected diseases. I consider this the most fundamental question in explaining the neglected diseases problem, as it relates to the very first phase of innovation, and thus it is at the root of the GHC, as I will show in chapter 4.

4. Thesis Outline

This thesis aims to provide a framework for analyzing the moral responsibilities of global players related to the GHC, devoting special attention to the moral responsibilities of pharmaceutical companies. The main contribution of this thesis will be to provide a general account of the moral responsibilities of global players, mapping the different kinds of duties they have, their content and force, their relation to the duties of other relevant players, and connecting this analysis with current debates on the need for reforms of the international legal rules addressing the GHC (i.e. the TRIPs regime).

As any argument about allocation of responsibilities for a common problem requires, I began the introduction by explaining *why* the problem (i.e. GHC) is a common problem that requires remediation, and along the following chapters, I will explain *what* the object of the responsibility is, *who* the agents responsible for discharging said responsibility are, and *how* this responsibility can be discharged. Accordingly, this thesis has three parts: Part A (comprising chapters 1 and 2) addresses the 'what' question, and discusses the content of the responsibilities for the GHC. Part B (comprising chapters 3 and 4) addresses the 'who' question, and clarifies the relational aspects of these

responsibilities and their different scopes. Finally, Part C (chapter 5) addresses the 'how' question, and discusses some possible ways of implementing said responsibilities.

Part A comprises chapters 1 and 2 and answers the question 'What is the object of the responsibilities for the GHC?' The central argument in chapter 1 is that there is a fundamental normative distinction between basic and non-basic health needs, and that this distinction is blurred in mainstream doctrine and international legislations, which conflates the two categories under what I call 'the well-being conception of health'. I argue against the unworkable well-being conception of health by engaging with James Griffin's idea of well-being, and I suggest 'the minimalist conception of health' as a more feasible alternative. Based on David Miller's idea of basic human needs, I define basic health needs in relation to a 'minimally decent human existence' (i.e. subsistence). The principle of justice behind this idea is that we presumably have stronger duties in relation to the more stringent health needs that relate directly to our minimally decent existence (i.e. subsistence), as opposed to less stringent health needs that relate to non-basic health needs.

Building on my argument in favor of the minimalist conception of health, according to which basic health needs are the object of the (basic) right to health to be protected in the context of the GHC, chapter 2 then discusses the controversies over the duties corresponding to the right to health both in the political and philosophical realms. In this regard, I engage with the disagreements, within the political realm, between the two UN independent experts on the issue, John Ruggie and Paul Hunt. Subsequently, I engage with the theoretical disagreements among philosophers, discussing Onora O'Neill, John Tasioulas, and Thomas Pogge's ideas. Analysing these technical disagreements will prove important in framing the issue around what is the common ground among different

views. As we will see, it is widely accepted that there is a negative responsibility to respect the right to health: this is the common ground among different schools of thought. Building on Pogge's idea of a negative responsibility to respect human rights, I will argued that the responsibility to respect the human right to health entails a duty not to violate the right to health, as well as a duty to remediate violations to the right to health, such as the GHC.

In Part B, this thesis discusses, along chapters 3 and 4, who the responsible agents are for remediating the GHC. While chapter 3 discusses states and natural persons as agents of justice, chapter 4 focuses solely on pharmaceutical corporations as specific agents of justice. The general idea of these two chapters is to clarify what we – as global players -- owe to other individuals when it comes to health needs, as a matter of justice, and not only benevolence. When we are organized as democratic states, when we are standing as individual citizens, when we are gathered as civil society or corporations – we will be, in each of these situations, fulfilling different social roles. There is a need for all these differentiations. The basic idea is that different relationships justify different responsibilities: different actors bear different degrees of responsibility for one another, not only because they have different capacities, but also because they have caused or contributed to the problem in different levels. These questions will be addressed in chapter 3, where I engage with Miller and Pogge to provide a normative basis for arguing that both states and non-state actors have a duty of justice to remediate the GHC (as defined in chapter 2), on top of benevolent reasons to help the distant poor and ill. Chapter 3 also provides a justice-based argument that is missing from mainstream public international law and human rights legislations, as the latter only consider state actors as bearers of human rights responsibilities. I argue, on the contrary, that non-

state actors should also bear part of those responsibilities of justice related to the right to health, as a basic principle of Global Commutative Justice (GCJ).

One crucial non-state actor directly related to the GHC is pharmaceutical corporations, as the owners of vital medical knowledge, protected by patents. In chapter 4, I explore whether there are certain responsibilities of justice attributable specifically to pharmaceutical corporations, in relation to the GHC. I argue that under the context of the GHC, pharmaceutical companies have the responsibility to disclose some of their medical patents, when such life-saving patents are vital to remediate the catastrophic death toll. This is a specification of a duty to remediate the GHC (as defined in chapter 2) that applies to pharmaceutical firms in particular. In chapter 4, I discuss three theories of private property, Thomas Aquinas', John Locke's, and Robert Nozick's, to show that my argument holds under all three theories – even under Nozick's views, which are considered most favorable to the exclusivity of private rights.

Finally, in Part C, this thesis discusses at a general level how the duties to remediate the GHC can be most adequately specified, allocated to the relevant agents, and legally enforced by international law. In chapter 5, I will discuss how the principles of justice considered in both parts A and B can inform the global health governance related to the GHC - particularly its dual problem of lack of access to medical knowledge and medicines for neglected diseases. There is a plethora of global institutions addressing the current health crisis. One way of classifying them is by distinguishing between those who ground their policies on the idea of benevolence towards the poor and ill, and those who ground their policies on the idea of justice and systemic remediation of the neglected diseases problem. I have called the first group 'the benevolence-based policies', as they focus on voluntary remedies. They comprise numerous policies, and

chapter 5 will discuss some of them, including: pharmacophilanthropy, differential pricing, voluntary licensing and bulk buying. I will address their main advantages and limitations in relation to the GHC and the latter's dual access problem. Then, chapter 5 will discuss the second group of existing policies and policy proposals featuring enforceable remedies through systemic reforms. I have called this second group 'the justice-based policies', as they focus on systemic and enforceable remediations of the GHC. Since chapter 5 is particularly interested in analyzing how the duty to remediate the GHC can be specified, allocated and enforced, I will focus on justice-based policies, since only duties of justice can be demanded and enforced through the law. Finally, I analyze in detail one proposed institutional alternative within the justice-focused group, namely the Health Impact Fund (HIF). I will use the HIF as an example to show how the moral framework proposed by this thesis can be applied in detail.

Part A. Defining the Object: What is a reasonable human right to health?

Part A encompasses chapters 1 and 2, and explores the question of what counts as 'health' with regard to debates on the right to health.

The conception of health that international organizations, such as the UN and the WHO, currently employ and propagate is problematic. I call it 'the well-being conception of health'.

Chapter 1 argues that this conception is not sophisticated enough. For the purposes of both moral deliberation and the crafting of feasible political and legal institutions, the differentiation between basic and non-basic health needs is key. It is important to keep this distinction in mind because the major aspects of the current GHC relate to health needs that are basic. Nevertheless, 'the well-being conception of health' conflates these two categories under one label of general 'well-being'. As a result, we risk not only confusing different sorts of moral claims, but also weakening the overall argument for the right to health-related duties.

'The minimalist conception of health', according to which basic health needs are the object of the (basic) right to health to be protected in the context of the GHC is proposed in chapter 1. Following this, chapter 2 builds on the widely accepted premises of a negative responsibility to respect the right to health. Chapter 2 argues that the responsibility to respect the human right to health is two-fold: it entails a duty not to violate the right to health, as well as a duty to remediate the violations of the right to health, such as those of the GHC.

Chapter 1 – The Moral Value of Health: Health as a Basic Human Need

In this chapter I will argue against the current mainstream international law understanding of 'health', which I will call 'the well-being conception of health'. I will propose a more differentiated understanding of 'health' based on the idea of basic health needs. My aim is to show the necessity of making a distinction between basic and non-basic health needs; a distinction that the well-being conception does not make. The well-being conception conflates under the same label very stringent requirements of health with matters that are simply desirable, or even a luxury. The distinction between basic and non-basic health needs is crucial, especially in real life decision-making regarding the GHC, where resources are very limited, and priorities need to be set. The difference between basic and non-basic health needs is also crucial because different rights and duties are related to those different aspects of health.

To show the difference between basic and non-basic health needs, I will first discuss the familiar UN and WHO understanding of health as well-being, and show in section 1 the problems of the existing 'well-being conception of health'. As an alternative to 'the well-being conception of health' I will suggest in section 2 what I will call 'the minimalist conception of health', based on David Miller's idea of a 'minimally decent human'. This alternative is capable of differentiating between basic and non-basic health needs, and it is thus capable of capturing the most stringent requirements of health. In this thesis I will focus on basic health needs because these are the stringent requirements of health that are at stake in the GHC.

After highlighting the problems with 'the well-being conception of health' in section 1, and suggesting an alternative based on the idea of basic health needs in section 2, I will

discuss James Griffin's theory of well-being in section 3. Griffin's theory is key, not only because he gives a complete account of well-being, but also because he particularly argues against the idea of basic needs. In this vein, I will discuss Griffin's objections against the basic needs account, in order to further refine my own account of the basic health needs and my critique of the well-being conception.

1.1. The existing well-being conception of health and its problems

Which definition of 'health', and thus of 'right to health', most adequately justifies the moral requirements associated with the GHC? In this chapter I explore the different understandings of 'health' that are related to the GHC. The point is not to provide a definition of 'health' for the dictionary, or an elucidation of that concept for the medical profession. The point is to elucidate the concept of health as *the object of rights and duties.* In this chapter, my main concern is to argue for a distinction between different aspects of health. It is important to make this distinction in debates on global justice, human rights and international law, because these aspects deserve different moral treatment. I will here start by engaging with an understanding of health that does not make such distinction, and which is the prevailing understanding in debates related to the GHC.

The GHC is a matter of concern for different global players, as we shall see in chapters 3 and 4. Nevertheless, it raises direct concerns, particularly for the WHO and the UN: the WHO is the specialized agency of the UN that has special authority for global health issues - including thus the GHC; and the UN is the chief international organization that has the political authority for human rights issues - including right to health issues and thus the GHC.

As the major authorities, the WHO and the UN provided the initial conception of 'health' in the 1940's, and this conception still provides the basis for all ongoing discussions of 'health' and 'right to health' as objects of different sorts of legal protections and regulations by the different international law systems. In other words, the definition of 'health' and 'right to health' that these two international organizations provided establishes the foundations from which all current debates on global health (including the GHC) spur; and this is the reason why here I will focus primarily on the definitions provided by these two international organizations. In this section, I will first explain the WHO and the UN existing definitions of 'health' and 'right to health', and then I will discuss their inadequacy for addressing the precise moral requirements associated with the GHC.

The WHO provided in 1946 the first definition of 'health': according to the preamble of the WHO Constitution, health is 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'. Subsequently, the 1948 Universal Declaration of Human Rights (UDHR) endorsed the idea that health is linked to the overall well-being of a person, while in a more modest tone, stating in Article 25.1 that 'everyone has the right to a standard of living *adequate* for the health and well-being of himself and of his family' (emphasis added).

The idea of a 'right to health' was first set out in Article 25, more than 60 years ago. Since then, Article 25 has been the subject of extensive work and debate seeking to refine our understanding of the right to health. The UN General Assembly, the Economic and Social Council (ECOSOC), the Human Rights Council (HRC) and its predecessor the UN Commission on Human Rights, as well as human rights special procedures – the

works of the special rapporteurs on the right to health in particular – all have produced a myriad of treaties and complementary documents aiming to specify what the right to health should look like.

The UN currently defines the 'right to health' as 'an inclusive right', which arguably can only be fully understood with reference to the so-called 'social determinants of health'[39]. The idea of the 'social determinants of health' includes any social-economic condition that may impact people's health, and that are preconditions for people's overall well-being and 'healthy life'. The UN explains the right to health in relation to the 'social determinants of health' in the following way: the 'right to health' is 'an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information'[40]. Accordingly, 'the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment'[41].

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[39] The conception of 'social determinants of health' is broad. It is repeated in public health literature including, in essence, any social circumstance that is health-related and that has an impact on the health of people. As the WHO defines: 'The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels' (http://www.who.int/social_determinants/en/).

[40] *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art.12 of the Covenant)*, UN.Doc.E/C.12/2000/4, 11August2000, para.11

[41] Ibid, para.4

As defined by the international law, the 'right to health' is therefore a very broad term, and its richness is arguably best encapsulated by the familiar formulation: 'right of everyone to the highest attainable standard of physical and mental health'. Even though the term 'right to health' is commonly used as an 'acceptable shorthand'[42] to facilitate its mention during international negotiations and theoretical debates, it is argued that the full articulation 'right of everyone to the highest attainable standard of physical and mental health' is 'best in line with the international treaty provisions that proclaim not only the right to health care services, but also the right to a number of underlying preconditions for health'[43].

The phrase 'right of everyone to the highest attainable standard of physical and mental health' and idea of 'the social determinants of health' was consecrated in 1966 by Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which builds on Article 25 of 1948 UDHR, and which was later further specified in its associated General Comment No. 14, adopted by the ECOSC in 2000[44].

Ever since, this all-encompassing formulation has been continuously expanding in scope by subsequent legal instruments that kept adding and specifying new 'social determinants of health', ranging from 'food, nutrition, housing, access to safe and potable water, and adequate sanitation' up to 'healthy working conditions', 'maternal,

[42] Clapham, Robinson, Mahon and Jerbi, *Realizing the Right to Health – Swiss Human Rights Book*, vol. 3, 2009, p.17

[43] Toebes, 'The Right to Health,' in Eide, Krause, and Rosas (eds.), *Economic, Social and Cultural Rights: A Textbook*, 2nd ed., 2001, 169-190, p.170

[44] UN.Doc.E/C.12/2000/4, 11August2000.

child, and reproductive health', 'natural environments', 'non-discrimination and equal treatment'[45].

This conception of the right to health I will call 'the well-being conception of health': it ties health to overall well-being, and defines the right to health as a right to the highest attainable level of a person's complete physical, mental and social capacities. Such a conception explains the right to health in relation to an ever growing list of 'social determinants of health', which can include any social-economic condition that may impact any aspect of people's overall well-being or their 'healthy life'. This may range from the most basic human needs (such as adequate nutrition, shelter, potable water and sanitation), to other more specific and contextualized social-economic conditions, (such as 'sexual health care', 'material assistance to the disabled', 'equality and non-discrimination' on the grounds of gender, race, ethnicity, and minorities, as well as a 'healthy environment', and even a 'healthy workplace free from corruption'). The well-being conception of health provides thus an all-encompassing account of health, which goes beyond the merely basic health needs of a person to include all significant factors that may have a considerable impact in her life.

The problem with this conception is that defining health in terms of well-being makes the object of the right to health too broad and too inclusive, in such a way that it conflates very different realities of health, namely the basic and the non-basic realities, under one same label. The well-being conception of health obscures all of these important differences, by conflation and a lack of differentiation. But this distinction is of moral relevance for the purpose of specifying the object of the right to health. In the next

[45] UN.Doc.E/CN.4/2003/58, 13Feb2003, para.4, 25, 26

section I will show the relevance of the distinction between basic and non-basic health needs, by discussing the theory of basic needs. Based on this theory, I will introduce the idea of basic health needs, and argue for an alternative conception of health and the right to health. I will call this alternative 'the minimalist conception of health', as opposed to the 'well-being conception of health'.

1.2. Basic Health Needs and the Minimalist Conception of Health

In this section, I will introduce the idea of basic health needs, and propose an alternative conception of health: 'the minimalist conception of health'. The purpose of the alternative minimalist conception of health is to clarify the object of moral and legal rights and duties that the common good of health justifies and requires from a system of international law.

1.2.1. The Relevance of the Distinction Between Basic and Non-Basic Health Needs

Why is the theoretical difference between basic and non-basic health needs relevant? Because different rights and duties bear on these different realities of health. To demonstrate this, it is not necessary to provide a full account of those rights and duties, but only to demonstrate how the different aspects of health —the basic and non-basic needs of health— give rise to different moral requirements. A hypothetical example may help us understand the distinction between the two: suppose that you are walking down the street, and come by a person who is about to die unless she receives a certain pill, and, at that moment, you happen to have a few in your pocket. You would surely have a stronger duty to provide said pill to that person, than you would have to, say, provide a nose operation to that same person so that she could look slightly better, or breathe slightly better, and snore less. The pill refers to a situation involving basic health needs.

As I further explain below, there are three conditions that classify basic health needs: (i) they are vital and indispensible; (ii) they are directly related to the survival of the person; and (iii) they impose strict duties on others. All other health needs that do not satisfy these three conditions are non-basic health needs: they are not indispensible for survival, and they are less forceful. The aforementioned nose operation would therefore refer to a situation involving non-basic health needs.

Presumably, we have stronger duties in relation to the more stringent health needs that relate directly to our survival, as opposed to less stringent health needs, which are not indispensible for one's subsistence. This moral intuition can accommodate a looser language of well-being, too. In the hypothetical example, both situations would fall under the well-being conception of health: both the indispensible pill and the convenient nose operation contribute to one's well-being. However, the rights and duties at stake in each of these two realities, are, *ceteris paribus*, of different weights: the duties connected to the indispensible pill are stronger than the duties connected to the convenient, but dispensable, nose operation.

So, if there are certain health needs that are basic, and if we presumably have stronger duties in relation to basic health needs than non-basic health needs, then this distinction is morally relevant. If the hypothetical example and the moral intuition we offer are sound, then it would make sense to distinguish between situations where the right to health would be more severely violated, thus entailing more forceful duties, and others where the violation would be less severe, whereby the corresponding duties would not be as strong. In order to make sense of basic health needs and their moral priority over non-basic health needs, I will now discuss the theory of basic health needs.

1.2.2. The Idea of Basic Health Needs

What is a 'basic' health need? A number of authors have engaged with the idea of basic needs, and with the basic needs account of human rights. It is a widely accepted idea that basic human needs are 'basic', as opposed to non-basic, because (i) they are 'vital' to any human life, and 'indispensible' for the exercise of any other human need[46]. Therefore, (ii) they set the minimum conditions for 'subsistence'[47] – meaning 'a minimally decent human existence'[48]. And as a moral implication of something being a 'basic' need, it is also widely accepted that they are premises for grounding 'universal moral imperatives'[49] with 'moral urgency'[50] - meaning 'minimum reasonable demands upon the rest of humanity'[51]. Basic Needs, therefore, are premises that justify duties on others.

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[46] For the idea of 'basic', see Shue, *Basic Rights – Subsistence, Affluence, and US Foreign Policy*, 1980, p.19

For the idea of 'vital', see Wiggins and Dermen, who emphasize that basic needs are 'categorical' and 'absolute' (Wiggins and Dermen, 'Needs, Need, Needing', in *Journal of Medical Ethics* 13, 1987, 62-68, p.65)

[47] For the idea of 'subsistence', see Shue, 1980.

Braybrooke defines basic needs as the 'conditions to live and function adequately' in *Meeting Needs*, 1987, p.31

Jeremy Waldron gives a complementary yet similar definition, explaining basic human needs in terms of a 'bearable' life in 'dignity.' (Waldron, 'Rights and Needs: The Myth of Disjunction', in Sarat and Kearns, *Legal Rights – Historical and Philosophical Perspectives*, 1997, pp.92, 105)

[48] Miller, *National Responsibility and Global Justice*, 2007[A], p.181

[49] Ibid, p.180

[50] Ibid, pp.180, 185

[51] Shue, 1980, p.19

Shue, Waldron (1997), Wiggins and Dermen (1987) all emphasize that basic human needs shape the minimal duties and responsibilities we owe to each other as human beings with equal dignity.

Miller provides the most complete theory of basic human needs, and their connection to human rights[52]. Miller explains basic human needs in terms of 'moral urgency', 'harm-avoidance', and 'minimal decency'. I will discuss each of these characteristics in turn.

First, basic human needs, as opposed to non-basic human needs, consist of 'what is essential', as opposed to 'what is non-essential'[53]. The basic, essential, human needs provide the 'moral urgency that we look for in a justification of human rights'[54]. According to Miller, basic human needs provide the most adequate justification for human rights. As he explains: 'since human rights are supposed to constitute a kind of moral bedrock – meeting them is a moral imperative, whereas other claims impose weaker duties or none at all – they should be justified by reference to essential features of human life. Needs possess this kind of moral urgency.

Miller actually focuses on what he calls 'basic human rights', which is 'a subset of those sometimes listed under this heading, distinguished by a compelling moral force of claims they represent'[55]. And for Miller, only the violation of these basic human rights – i.e. only the cases where basic human needs are not met or are withheld – provide reasons urgent enough to justify stringent demands on others to remediate such harm. As he puts it: 'In drawing this line between basic human right and the longer list that can be found in some human rights documents, I am assuming that only certain right-violations

[52] For other treatments of the idea of basic human needs, see Shue, 1980, p.19; Wiggins and Dermen, 1987, p. 65; Braybrooke, 1987, p.31; Waldron, 1997, pp.92, 105; Miller, 2007[A]

[53] Miller, 2007[A], p.180

[54] Ibid, p.185

[55] Ibid, p.164

are urgent enough to trigger remedial responsibilities'[56]. In sum, for Miller, basic human needs, in capturing what is essential, provide the adequate justification for basic human rights, and only a basic human right violation provides urgent enough justification to ground a remedial duty on others[57].

Second, for Miller, on top of being 'moral imperatives' with 'moral urgency'[58], when basic human needs are unmet, the deprived person is harmed, and thereby her basic human right is violated[59]. As he puts it: basic human needs are 'items or conditions that it is necessary for a person to have if she is to avoid being harmed'[60]. Harm justifies 'remedial responsibility'[61]. Miller then clarifies what counts as harm. The most obvious cases of harm, as he explains it, are those physically or bodily-related. Accordingly, a person is harmed when she is subjected to pain or suffering, or diseases that impair her proper functioning as a human being, or that 'prevents her engaging in the normal range of human activities'[62]. Miller then goes on further to complement this initial definition, by adding that:

[56] Ibid, p.167

[57] Ibid, pp.164, 166-8, 179-185

[58] Ibid, p.180

[59] Ibid, p.182

[60] Ibid, p.180

[61] Ibid, p.167

[62] Ibid, p.181

> Physical-cum-biological conceptions of harm, although important, are not by themselves sufficient to generate needs that can ground an adequate set of human rights. Human beings are social as well as biological creatures, and they can be harmed by being denied the conditions of social existence. I shall capture this idea by saying that a person is harmed when she is unable to live a minimally decent life in the society which she belongs. A minimally decent life, I shall stress once, is something less than a flourishing life.[63]

It is in this context of explaining 'harm avoidance' that Miller introduces the third aspect of his idea of basic human needs, namely the 'minimal decency'. Miller's idea of basic human needs is based on his conception of 'a minimally decent life'. And he adds that:

> [t]he idea of a minimally decent life illuminates needs because it draws attention to the fact that the needs that matter are not merely the needs of a person considered as a biological creature in isolation from others, as the needs for food and water are. They are also the needs of a person who belongs to a community and who views her life through the lens of that community.[64]

For Miller, therefore, basic human needs also have a societal aspect that complements and specifies their universality. This is why the 'items or conditions' for 'minimal decency' are universal, and yet are context-sensitive, as they can only be specified by 'social norms that we should expect to vary from some extent from place to place'[65]. Miller as

[63] Ibid, p.181

[64] Ibid, pp.181-2, n.27

[65] Ibid, p.182

well as the other authors[66] emphasize that basic human needs are 'universal moral imperatives': they are 'a baseline that everyone should reach regardless of whether they are able to achieve higher forms of flourishing above it'[67]; as such, these conditions for a minimally decent life are 'universal', as they 'are the same for everyone'[68], applying to every human being everywhere.

Miller therefore differentiates basic needs by drawing a distinction between basic human needs that are universal, and what he calls 'societal needs' that vary according to contexts. As he puts it:

> [T]he former are to be understood as the conditions for a decent human life in *any* society, and the latter as the more expansive set of requirements for a decent life in the particular society to which a person belongs. Only basic needs can be appealed to in order to ground human rights. Societal needs, by contrast, are used to justify what I earlier called rights of citizenship – the larger set of rights, possessions of which guarantees someone's position as a full member of a particular society, and whose content will vary somewhat from one society to the next.[69]

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[66] Braybrooke (1987) and Wiggins and Dermen (1987) also emphasize the universal yet context-sensitive (depending on time, place and other circumstances) aspects of basic human needs.

The capability approach to human rights also builds on this idea of universality and plurality or context-specificity. For the original capability approach, see Sen and Nussbaum. For a capability-based approach to health rights, see Ariana and Naveed, 'Health,' in Deneulin and Shahani, eds., *An Introduction to the Human Development and Capability Approach – Freedom and Agency*, 2009, 228-45, available at http://web.idrc.ca/openebooks/470-3/), and also Ruger, *Health and Social Justice*, 2010.

[67] Miller, 2007[A], p.181

[68] Ibid

[69] Ibid, pp.182-183

Miller thus shows the moral relevance of basic health needs: he argues the needs account provides the best justification for human rights, because the idea of basic needs can best capture the 'moral urgency' necessary to ground basic human rights. The urgency of basic human rights is better explained in the context of their violation, because the very purpose of human rights is harm avoidance: when a basic human need is unmet, there is the infliction of a 'harm' (i.e. basic human right-violation) that requires remediation. 'Harm' for Miller only happens when someone falls below the tolerable baseline or threshold of 'minimal decency'. Falling below it is so degrading that it cannot be tolerated by others, and thus others will have a stringent duty to remediate that person's situation. For Miller, therefore, basic human rights grounded on basic human needs have the necessary moral urgency to justify stringent duties on others for the remediation of a degrading harm (i.e. an inability to live a minimally decent life)[70].

In brief, Miller's theory builds on and develops the shared understanding of basic human needs. So, for Miller, basic human needs are basic: they are universally vital and all human beings possess them qua human beings; they set the baseline or threshold of minimal decency that demarcates what can be tolerated and what cannot. Therefore, as a moral implication of being basic, they impose stringent duties of remediation of all situations falling below the baseline.

1.2.3. Basic Health Needs and the Right to Health

[70] Ibid, ch.7

I have discussed the broadly accepted idea of basic needs, and Miller's basic human needs approach to human rights. How then do these apply to my discussion of the right to health?

It is broadly accepted that a human need is considered 'basic' when it satisfies two main conditions. Likewise, I shall define certain health needs as 'basic' when the same two conditions apply: (i) they are vital to any human life, and indispensible for the exercise of other non-basic health needs; (ii) they set the minimal conditions for any 'minimally decent human existence', as defined by Miller. And as a moral implication of being 'basic', they are premises that can set universal moral requirements with moral urgency, as conceptualized by Miller; and therefore they are also normative premises that can ground stringent yet reasonable legal duties upon the rest of humanity, as suggested by both Shue and Miller.

Pertaining to the fact that basic health needs are moral and normative premises – i.e. basic health needs set universal moral requirements, whose stringency can reasonably ground legal duties on the rest of humanity -- two further clarifications need to be made:

First, for the purpose of arguing for the minimalist conception of health, I am defining basic health needs as universal moral requirements, with a normative implication: basic health needs are moral and normative premises that provide reasons to justify stringent duties on others. The idea of basic health needs provide the necessary reasons to justify stringent duties of justice that can be reasonably enforceable through the law. Surely, to be enforced through legal institutions, other reasons may apply. Nevertheless, this does not dismiss the moral relevance of basic health needs: basic health needs are morally relevant, as *necessary* conditions to ground moral and enforceable duties; they are not,

however, *sufficient* conditions to ground alone the legal enforcement of duties of justice. For example, the law may investigate the precise further specifications, including clear causal connections between the harm and the responsible agent, before imposing specific duties on said agent. Basic health needs are relevant moral and normative premises *necessary but not sufficient* to ground legally enforceable duties. Furthermore, not necessarily *whenever* a basic health need is lacking will a stringent moral requirement and legally enforceable duty on the rest of humanity automatically apply. In other words, not all circumstances of basic health needs deprivation will immediately impose on others a stringent legal duty to remediate the deprived's situation: the reasons and roots of that deprivation will have to be assessed in order to justify the imposition of duties on others. Certain duties of justice that can be reasonably enforceable through the law will be discussed and specified all along this thesis; I will discuss in the following chapters some specific circumstances where the law can and cannot reasonably demand the enforceability of particular obligations. But by now, it suffices to conceptualize basic health needs as a set of conditions we need in order to live a minimally decent human existence; these conditions ground universal moral requirements (i.e. basic principles of justice[71]) that apply to basic health needs, but not to non-basic health needs. Basic health needs and their universal moral requirements are *necessary but not sufficient* to ground enforceable duties of justice. Basic health needs are the *necessary* justification because they impose stringent moral requirements, with a stronger normative force compared to non-basic health needs, but in other to be enforced through the law, further specifications will be required. The normative force of basic health needs is what is *necessary* to justify what we minimally owe to each other in

[71] On the definition of basic principles of justice as 'universal principles of obligations', see O'Neill, *Bounds of Justice,* 2000, pp.136-7.

For a discussion of principles of justice, see chapters 2 and 5.

terms of health, and what others can, in turn, reasonably and minimally demand from international law institutions.

Second, for the purpose of arguing for the minimalist conception of health, I define basic health needs as universal moral requirements; a conception which only addresses those aspects of well-being that are necessary to guarantee a minimally decent human life. The well-being conception of health encompasses basic health needs as well as all the remaining aspects of overall well-being -- including wants, desires and conveniences, which may be universal and intrinsically good for one's state of being well and one's happiness, but are not strictly necessary for one's subsistence. Although the minimalist conception of health has a much narrower content than the well-being conception, the mere setting down into a list of universal basic health needs and universal non-basic health care treatments and procedures cannot fully capture this moral division between these two different realities of health.

It is a universal truth that *any* human being requires basic health needs first and foremost to subsist; only then he can have the conditions to flourish and live his life to the fullness of his well-being. However, it is also true that the precise content that makes concrete this universal truth varies from one place to another, and from time to time, and only medical specialists would be capable of specifying the full details of such content. The specific items that could figure within a list of basic health needs, as individual prescribed goals towards the achievement of 'the minimally decent standard of living,' are multiple and context-dependent. Likewise, the specific items that could figure within a list of non-basic health needs, as individual prescribed goals towards the achievement of a flourishing life lived to the fullness of one's well-being, are multiple and context-dependent, too. There is a vast and specialized literature in Medical and Public Health

Ethics discussing the adequacy of various lists[72]. It goes beyond the scope of this thesis to suggest any list of what should count and should not as a basic health need.

For our purposes, it is enough to say that the idea of basic health needs, as opposed to non-basic health needs, is especially relevant in the context of the GHC: basic health needs are what is at stake in the context of the crisis. Basic health needs are morally relevant because they are the objects of certain (basic) rights and (stronger) duties, which are more stringent that other putative non-basic rights and duties, which may also apply to matters of health. In the situation of the GHC, however, what is clearly at stake are basic health needs. To be sure, the 'right to health' as well-being is referred to in international human rights documents as an all-inclusive right that encompasses many sorts of duties – basic and non-basic alike. Of those duties, the ones that are associated with the GHC are associated with basic health needs, and will be *ceteris paribus* more stringent, more important, and more urgent. For this reason I will focus solely on this reality of health over the course of the following chapters. My reason for highlighting the distinction between basic and non-basic health needs is to underscore the stringency of the health requirements that are at stake in the GHC.

Although the well-being conception accommodates the idea of basic health needs, it still makes sense to distinguish the different realities of health, namely the realities of basic and non-basic health needs. The well-being conception does not deny the premise that certain aspects of health are first and foremost a basic human need, before being an element amounting to overall well-being. It is widely acceptable, as I have discussed in this section, that certain aspects of health are basic because they are vital to human

[72] See, for example, Ariana and Naveed, 2009; Ruger, 2010; Daniels, *Just Health – Meeting Health Needs Fairly*, 2008.

existence, and they are indispensible not only to the exercise of any other human need, but also to achieve overall well-being. This is the shared premise among different authors, those who argue for a basic health needs account of human rights (such as Miller, discussed above), and those who will endorse a more all-encompassing account (such as Griffin, to be discussed in the next section). If everybody agrees that the well-being conception of health does not deny the existence of basic health needs, and that the right to health is more compromised in cases where there are basic health needs at stake, and less compromised where there are none, then what is the problem with the well-being conception, given that it also allows one to distinguish between basic and non-basic health needs? The well-being conception of health might be kept as long as these different realities of health are made clear within the existing concept of the right to health. Yet, keeping this concept seems unhelpful as it has been inviting the confusion and dilution of the moral priority of basic health needs: an adequate conception of health should express clearly the relevant differences, and not just leave things underdetermined.

In the next section, I will focus on Griffin's prominent theory of well-being, which seems particularly interesting for our purposes because it engages precisely with the basic/non-basic difference. As I will set forth in Section 3, Griffin acknowledges that 'we have two concepts of well-being, one broad and the other narrow. Both, no doubt have their uses. But only the second, it seems, suits morality.'[73] Griffin is also searching for a narrower idea within the loose conception of well-being. However, while he distinguishes between the notions of what he calls 'broad' and what he calls the 'much narrower notion that

[73] Griffin, *Well-Being: Its Meaning, Measurement, and Moral Importance*, 1986, p.40

suits moral theory best'[74], he emphatically opposes the basic needs approach to human rights. He raises a number of objections to this end, and though they might not be conclusive, they nevertheless bring to the fore important issues that my idea of basic health needs must tackle in order to be persuasive enough to ground a view of the right to health with enforceable correlated duties. It is only once we have a robust view of what constitutes basic health needs that we can formulate reasonable and plausible globally shared responsibilities concerning certain aspects of health of all human beings (as I shall discuss in chapter 2), to be enforced through global institutions (as I shall discuss in chapter 5).

1.3. Griffin's critique of Basic Needs

Griffin explains basic human needs as those 'we all have just by being human'[75]. They are 'not only basic but also absolute: humans need food and rest and health'[76]. For Griffin, 'the rough explanation of basic needs is clear: they are what we need to survive, to be healthy, to avoid harm, to function properly'[77]. Griffin conceptualizes basic human needs around these three key concepts: ailment, harm, and malfunction[78]. These concepts demarcate and justify the basic human needs' normative force over non-basic needs. They make up a minimal threshold of human existence, and falling short of it triggers especially strong obligations on others. As he puts it,

[74] Ibid, p.41

[75] Ibid

[76] Ibid, p.42

[77] Ibid

[78] Ibid

> [t]he presence of the notions of health, harm, and proper function make statements of basic needs normative […] They all involve a norm falling below which brings malfunction, harm, or ailment. And this explains why basic needs have an especially strong link with obligation: my ailment makes a claim on others that my whims, hankerings, pleasures, and even happiness cannot. And these claims on others are of a strong sort.[79]

Griffin's explanation of basic human needs is illuminating for the purpose of showing that health is indisputably a basic need. Even though he later refutes the basic needs account, arguing instead for what he calls 'the personhood account' based on a 'worthwhile life of a normative agent,'[80] he explicitly agrees with our point that the well-being conception of health is inadequate, when he stresses: 'health is not equivalent to "well-being", although the World Health Organization, in the Preamble to its Constitution, in effect declares that it is.'[81]

This, nevertheless, does not mean that Griffin would agree with our proposed minimalist conception of health, based on our account of basic health needs. Rather, Griffin spells out three main problems with the basic needs language: (1) that it is too indeterminate[82]; (2) that it is too rigid and not sensitive enough to the specificities of each social setting[83];

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[79] Ibid

[80] Ibid

[81] Ibid, p.101

[82] Ibid p.42

[83] Ibid, p.45, 55

and (3) that it is too meager[84]. In the following sections, I describe and discuss Griffin's objections against the basic needs account on the grounds of their purported indeterminacy, inflexibility, and insufficiency. If proven to be correct, Griffin's objections may deal a fatal blow to my initial claim for a conception of health based on basic health needs, for the purposes the rights and duties related to the GHC.

1.3.1. Objection One: The Indeterminacy of Basic Needs

Griffin starts his attack against the basic needs account pointing out that it is too indeterminate. The reason for this problem, according to Griffin, is that three key concepts (ailment, harm, and malfunction) are so indeterminate that they are unable to provide any determinateness to the account as a whole. Griffin points out the problem of indeterminacy, and suggests a solution to introduce more determinateness to the basic needs account. He writes:

> The key notions of "ailment", "harm", and "malfunction" are too indeterminate. […] There are many ways of introducing more determinateness. We could try developing the idea of a minimum provision. We need a certain amount (not only of resources, but also of leisure and education) to be able to make something valuable of our lives; what we have beyond that minimum amount may make our lives pleasanter or easier, but it is not necessary to the basic task of living a worthwhile life. If one does not have that amount, then one's life is maimed. I do not want to gainsay any of this. This notion of the minimum ingredients of a worthwhile human life is indispensible to moral theory; for one thing, we could

[84] Ibid, p.55; see Griffin, 2008, p.180

> give no adequate account of "natural" or "human" rights without it. Since the notion is indispensible, it has to be made determinate. But it is certainly not determinate yet. How much education would the basic kit contain? Literacy? Enough to ponder the meaning of life? And what level of health? When life expectancy is thirty, or fifty, or seventy?[85]

In the passage below, there are two important points regarding Griffin's claim on the indeterminacy of basic health needs. First, Griffin says that the 'key notions of "ailment", "harm", and "malfunction" are too indeterminate'[86], and by saying this, he is claiming that the basic needs idea is founded upon notions that are too vague. Second, Griffin here suggests that such indeterminacy of the basic needs account could be solved by 'measuring' what he calls 'the minimum provision' of each of the basic 'ingredients' of what he calls 'a worthwhile human life'; he will then explain how this "measurement' or 'stipulation' is related to his key idea of 'a worthwhile life', as I shall explore below[87]. The first point relates to Griffin's claim on what I shall name 'the content indeterminacy', and the second point relates to Griffin's solution to solve this indeterminacy. His solution, nevertheless, tackles a different form of indeterminacy, which I shall later call 'the normative indeterminacy'. To be sure, Griffin points out the problem of the content indeterminacy of basic needs, and then proposes a solution to the normative indeterminacy to basic needs. I will now discuss these two forms of indeterminacy (i.e.

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[85] Ibid, pp.42-43

[86] Ibid, p.42

[87] 'This notion of the minimum ingredients of a worthwhile human life is indispensible to moral theory.' Ibid, p.43.

content and normative) in the context of Griffin's first objection to the basic needs approach.

The Problem: The Content Indeterminacy

Griffin argues that the basic needs idea is founded upon notions that are too vague, and thus the whole enterprise of the basic needs approach is presumably undermined by this underlying vagueness. As he puts it: 'I am saying that "basic needs" is too indeterminate to do the work assigned to it, that it cannot be made determinate by pointing out its links to notions indeterminate in much the same way.'[88] To illustrate his point on the indeterminacy of basic needs, Griffin engages with a few examples. He contrasts the obvious example of food with some less obvious example, such as an interesting work, and education:

> It is no good repeating the obvious example of food: certainly without food we shall ail. But it is not enough that a few needs fall clearly one side or the other of the boundary of "basic needs" if most sit right on the line. Is interesting work a basic need? Well, without it, alienation, a kind of social pathology, results. Is education a basic need? Without it, one's intellect will atrophy. And how much education?

Griffin is questioning the clear boundaries that have been laid out regarding what precise elements qualify as a basic need, and what do not; and he argues that only a few need are indisputably basic; for all the rest (including 'interesting work', and 'education') there

[88] Ibid, p.328, n.13

is no definite answer. Indeed, it is by no means an easy feat specifying the exact elements of a list of basic needs. As discussed above, the distinction between basic and non-basic health needs is morally relevant, independently of the provision of precise lists differencing the basic and non-basic. The distinction remains morally relevant even before the difficulties and uncertainties of the task of defining what counts as a basic need -- sometimes there might not be a clear answer at all, but this is not a reason for abandoning the basic need approach altogether. A relevant and important distinction cannot simply be dismissed because sometimes it is not clear how it applies in practical terms. Vagueness is a pervasive feature of our language, and this also applies to normative concepts. There is always a need for further reflection on what falls on each side of a distinction, on what is included and excluded by a normative concept. This is why any legal system has to operate with vague concepts, finding ways to achieve its ends through vague concepts[89].

In reality, moral reasoning will only take us so far and at some point, within reasonable margins, a line must be drawn. Sufficient and compelling reasons can justify drawing such a line and distinguishing between categories, even if there are practical difficulties associated with assigning the content of each category in real life. Let us take the example of the concept of poverty. The idea of 'very poor' is vague and the task of specifying who belongs to this category is a difficult one. Nevertheless, we still need this conception because it is normatively relevant for the purposes of institutions dealing with poverty-related problems, such as when it comes to distributive justice and designing tax systems that applies to a certain segment of the population but not to the others. The same can be said of basic health needs: vagueness, difficulty or uncertainty about what

[89] Endicott, *Vagueness in Law*, 2002, ch7

falls into the category is not reason enough to abandon the idea, We still need this conception because it is normatively relevant for the purposes of institutions dealing with public health problems. And not only that: we can still apply it uncontroversially in many cases, particularly in those related to the GHC. The GHC deals chiefly with health needs that are basic, and, as such, give rise to stringent duties, which require specific institutions to realize them. Certainly, there will also be borderline cases, as with every concept. Nevertheless, the very notion of basic health needs draws our attention to a morally relevant distinction, which can be applied without contention in many relevant cases.

Griffin's proposed solution: adding normative determinacy through informed-desires

Griffin suggests that the content indeterminacy of the basic needs account could be solved by stipulating 'the minimum provision*'* of each of 'the minimum ingredients' of 'a worthwhile human life*'*.[90] Griffin's idea of 'a worthwhile life' is the key concept to explain his normative solution to the content indeterminacy of the basic needs account. His claim is that 'the idea of "basic needs" is too indeterminate to do the work assigned to it'[91], meaning the work of pointing out the strongest moral duties, and of justifying their urgency or priority over other values. Griffin therefore will propose an alternative concept that can better do the work of pointing out the strongest moral duties, and of justifying their urgency or priority over other values: this is the idea of *'a worthwhile life'*, meaning

[90] 'This notion of the minimum ingredients of a worthwhile human life is indispensible to moral theory.' (Griffin, 1986, p.43).

[91] Ibid, p.328, n.13

'what is needed to function as a normative agent' and 'which is substantially more than just subsistence'[92].

For Griffin, a 'worthwhile human life' has three components: autonomy to choose, liberty to act, and 'the minimum provision' of 'resources and capacities' that enable each individual to choose and pursue his 'desired outcomes' that lead him towards his own ideal of a life worth living[93]. Griffin's personhood account emphasizes one special type of desire, which he calls 'informed-desires', and this is precisely what Griffin claims to give determinacy to his alternative account. For Griffin, these special desires are determined: they have a distinctive relevance in one's life. And because of this distinctive relevance for one's life, the 'informed-desires' become a central element of one's worthwhile living, in such a way that (i) without these informed-desires, life is not worth living; and thus (ii) these informed-desires can take priority over and above all other needs, including the most basic needs required for survival[94]. And because of their centrality in one's life, these definite '*informed-desires*' can take priority over general basic need, such as a basic health need[95].

Griffin claims that the fact that something happens to be categorized generally as a basic need does not automatically confer it priority; in real life specific cases, other reasons may apply and claim priority. In particular, certain '*informed-desires'* may be prudentially and morally relevant because of their heightened or irreplaceable

[92] Griffin, 2008, p.90

[93] Ibid, pp.44-48

[94] Griffin, 1986, pp.51-53

[95] Ibid.

significance in one's life, even if they are not related to any need (such as a basic health need). So, for Griffin, an 'informed desire' that is not indispensible for one's survival can take precedence over a basic health need that is indispensible for one's survival. An example is the case of the well-informed heavy smoker. His desire for a cigarette is informed: he is well-aware of all the possible negative consequences that heavy smoking may have on his health; nevertheless, the pleasure and happiness that he derives from inhaling the smoke of each cigarette may not only make up for these negative health consequences, but may place his smoking habit at the very center of what he considers to be his worthwhile existence. Griffin would probably say that, in this case of the well-informed heavy smoker, his informed-desires for the cigarettes could justifiably take precedence over and above his basic health needs (this would be justified by his values: the habit of smoking is what counts for making his life worthwhile, regardless of self-inflicting ailment, harm and malfunction that the habit of smoking may generate). Griffin is not denying the importance of basic needs; he is merely saying that they are not absolute – meaning they do not always take priority over everything else, precisely because their degree of importance will vary from one individual to the other. The personhood account and the basic needs account are thus compatible, as the former adds on the latter: the key concept of 'informed-desires' complements the basic needs account.

By explaining what informed-desires are, and saying that these definite and special desires can justifiably take precedence over general basic health needs, Griffin highlights that a number of specific reasons brought on by the complexities of real life have to be considered in practical reasoning: basic needs cannot be the single criterion. By saying this, however, Griffin has merely shown something that is standard in all moral reasoning, and that affects almost any moral principle proposing a distinction: we cannot

use the proposed distinction alone exclusively to guide our reasoning, since the prescriptions of the distinction may be limited or even outweighed by other circumstantial considerations. There is nothing in my argument, however, that entails that basic health needs will always have priority over all non-basic human needs (including informed-desires), regardless of other considerations. That the basic health needs idea is not the only moral distinction to be considered in the later stages of practical reasoning and legal adjudication for the definition and specifications of public health policies, does not invalidate my original point: that basic health needs provide a *prima facie* moral reason in favor of prioritizing them over non-basic health needs *ceteris paribus*, and that basic health needs are the object of very stringent and important requirements of justice.

The distinction between basic and non-basic health needs is thus morally relevant and pertinent: one single moral criterion does not need to be the sole determinant in all cases in order to prove its relevance and applicability. This is my reason for emphasizing this distinction in this chapter. My purpose is to highlight that some health needs are more stringent than others, and that this factual distinction is of moral relevance, because there are more stringent duties related to the basic health needs. For the purposes of the GHC, it is relevant to bear this in mind, because this crisis chiefly affects health needs that are basic.

1.3.2. Objection Two: The Inflexibility of Basic Needs

Griffin's second attack against the basic needs account points out that the account is 'too rigid' – meaning inflexible. The reason, according to Griffin, is that the needs account is insensitive to the particular cases of each individual, to his deepest desires, and to how the individual himself values things as 'important, vital and urgent' to his own

existence. Griffin therefore points out the problem of inflexibility, and then suggests a solution to introduce more flexibility to the basic needs account: he invites us to reflect on 'the stipulation' of how 'important, vital and urgent' each value is in one's life:

> Most needs accounts make the mistake of being too rigid; they rank basic needs above mere desires, regardless of the levels or amounts of satisfaction of each that are in question, which is implausible […] But the mistake can be corrected. We can introduce flexibility into need accounts by introducing a new notion: how important or vital or urgent a basic need is in a particular case.[96]

For Griffin, the rigidity of the basic needs account lies precisely in the fact that it completely excludes from its 'objective list' of 'important, vital or urgent' needs, certain values that may be equally if not more 'important, vital or urgent' in a particular case, for a particular individual. Surely, Griffin would agree, certain basic needs apply to all human beings. As he himself acknowledges: 'humans need food and rest and health – not *for* anything, they just do.'[97] These seem to be general needs: needs that are valid for all human beings. Everybody needs food, rest and health. Period. Griffin obviously does not deny these facts and truths. The point that Griffin is making, however, is that, it might be that, in particular cases, these basic human needs may not necessarily and automatically take precedence over certain other things that have utmost value (i.e. prudential/self-interest value) to that particular individual.

The Problem: The absoluteness and objectiveness of Basic Needs

[96] Griffin, 1986, p.55

[97] Ibid, p.42

For Griffin, food, rest and health are not necessarily 'absolute', in the sense that they will always necessarily have priority over everything else in every person's life. Food, rest and health are objective standards that apply to all human beings, but they are not absolute: the measurement of that importance and establishment of priorities will vary from one individual to the other, as we are all different. For example, the value of nourishment may be different for a scholar than for an athlete. As he puts it:

> A group of scholars may, with full understanding prefer an extension to their library to exercise equipment for their health. And part of what makes us think that basic needs, such as health, are more closely linked to [stronger] obligation than desires is that basic needs seem the 'bread' of life and desires mere 'jam'. But an extension of the scholars' library may not seem like 'jam' to them.[98]

Griffin explains through this example that the deepest and informed-desires of these scholars for an extended library can justify the compromise of at least part of their basic health needs. And this is perfectly justifiable for Griffin because 'the library is of greater value to them'[99]. But, according to Griffin, the basic needs account is insensitive to these variations of value across different persons.

The fact that scholars would be happy to choose compromising part of their basic health needs in exchange for an extended library does not mean, nevertheless, that their basic health needs are objectively less 'important, vital or urgent' for them. Furthermore, we

[98] Ibid, p.45

[99] Ibid

should be alert to the fact that, even though it is possible that someone prioritizes having a library over satisfying her basic needs, when thinking about these examples we sometimes imagine persons that have their basic needs already satisfied (as it is the case with scholars in developed countries). The hypothetical example of the scholars would be less persuasive if we imagined a scenario where they are starving, for example. Now, there is nothing in my argument that entails that basic health needs will always have be more important than all non-basic human needs (including informed-desires), regardless of other considerations. All I am conveying here relates to my original point that basic health needs provide a *prima facie* moral reason in favor of prioritizing them over non-basic health needs *ceteris paribus*, and that basic health needs are a matter of very stringent and important requirements of justice. So, at least in the cases of extreme poverty and severe scarcity and deprivation, such as the GHC, it is uncontroversial that some basic values (such as basic health needs) are objectively important for all human beings, even if subjectively their degree of importance may vary from one person to another, or other non-basic values (such as informed-desires) may in fact be more subjectively important for a person in particular. None of this is contrary to the normative importance of basic health needs, or its usefulness as a category. Nor is it contrary to the normative importance of making clear the difference between this category and the other category of non-basic health needs, for the purpose of crafting institutions defining the rights and duties associated with the GHC.

Griffin's proposed solution: adding flexibility through informed-desires

If an account is too rigid precisely because it ignores certain values that should not be ignored in stipulating what is 'important, vital and urgent', the way to add flexibility is to bring those values into account. Accordingly, Griffin adds the idea of 'informed-desires'.

Griffin's idea of 'informed-desires' can contribute to the flexibility that he takes to be a deficiency of the basic needs approach. As opposed to basic needs that are referred to as 'objective values'[100], 'informed-desires' are 'subjective': not only in the sense that they are 'more flexible, more sensitive to individual differences'[101], but also in the sense that they are 'self-interested values'[102], thus varying necessarily from one individual to the other. Griffin places 'informed-desires' at the centre of his theory, because he believes that this idea is capable of capturing the wholeness of his personhood account: the idea of 'informed-desires' is flexible enough to allow an autonomous agent to freely choose and pursue those deepest 'desired outcomes' that will make his life worth living[103].

For Griffin, flexibility is key to the process of stipulating what is important, vital and urgent. And flexibility will entail two aspects. First, in stipulating what is important, vital, and urgent one cannot overlook informed-desires, since the subjective idea of 'importance' will depend on the subjective idea of prudential/self-interested value:

> It seems impossible to form any estimate of how important the need is without appeal to the same standard that gives us the value of mere desire – namely how each affects the overall quality of life. And there seems to be no criterion by which to decide whether the demands of health are fully met, no matter how minimal we think these demands are, without seeing what else, including mere desires, people value and how greatly they value them. […] It is unlikely that the

[100] Ibid, p.54

[101] Ibid

[102] Ibid, p.4

[103] Griffin, 2008, pp.44-48

> conception of *importance* can be […] independent of our general conception of prudential value.[104]

On top of being attentive to informed-desires, the second aspect to which the process of stipulation has to be attentive is 'the measurement of how much' importance something has or has not in one's life, acknowledging those points where something ceases to be important at all. Griffin argues:

> A basic need, we can say, is generally less important the more it is already met, and at some level of satisfaction it will cease to be important at all. We can make how important it is also depend upon the level of satisfaction of other basic needs; if my needs for liberty and minimum material provision are not met, and are so unlikely ever met that life is not worth living, then health must matter less too.[105]

Here Griffin seems to equivocate between two different senses of 'important': one is the objective sense, in which we say that something is important when it is actually of much relevance to me, whether I know it or not; the second is the subjective sense, in which we say that something is important for someone in particular when it is of great interest for that particular person in that particular thing. Surely, in the subjective sense, basic needs are likely to occupy less the minds of those for whom they are already satisfied, to the point where these people may not even think about their basic needs at all. But that

[104] Griffin, 1986, pp.51-52

[105] Ibid

does not mean that objectively the relevance of those basic needs is smaller for them, or that these basic needs have no relevance at all for them.

It seems unlikely that food, rest and health can ever 'cease to be important at all'. They will always be indispensible, and in this sense, objectively important to any human being. This is precisely why they qualify as 'basic' human needs. All human beings, without question, need food, rest and health. Undoubtedly, 'how much' food, rest and health each human being will need is a matter of dispute. And surely, the overfed may require food to a lesser degree than the starving; the over-sleeping may require rest to a lesser degree than the exhausted; and the most vigorous and energetic person enjoying the highest attainable standards of her complete physical, mental, and social well-being may require health care to a lesser degree than a disease-stricken person. Nevertheless, the basic human needs conditions of food, rest and health always remain valid to every human life, even for the overstuffed, over-rested, and completely vigorous and energetic individuals. Even if we accept that, at certain levels of satisfaction of food, rest and health, for example, they can be subjected to ordinary senses of trade-offs and simple choices, it does not follow that basic human needs regarding these goods are not relevant.

In any case, his possibility of trade-off and choices does not seem to apply in the contexts of extreme poverty, such as those of the GHC, where the deprivation of the most basic needs are so extreme, that it seems almost impossible to imagine how trade-offs and choices among these most basic human needs could apply. Therefore, Griffin's theory of informed-desires as an alternative to the theory of basic human needs does not provide the answers on the subject of how to define what is 'important, vital and urgent' in the contexts of global poverty, and the GHC in particular. Even if we agree that, in

ordinary situations, what is 'important, vital and urgent' in one's life may be open to individual trade-off and choices beyond the standardized basic human needs and certain prudential/self-interested values (i.e. informed desires), this is not the chief matter of concern in the context of public health policies addressing the GHC.

The GHC is not the ordinary situation in the developed world: it is a crisis, where political decisions regarding scarcity of resources have to be made with urgency. In this particular context, the process of reasoning on what is 'important, vital and urgent' may be different from the ordinary situations, where urgent matters of survival are not the only element at stake. Even if one agrees that people's deepest desires and prudential feelings should be taken into account in the practical reasoning and legal adjudication for the specification of rights and duties over what is 'important, vital and urgent', this does not seem to provide any answers in the context of the GHC. In the midst of the GHC, the deprivation of even the most basic human needs does not concern choices based on 'informed' sentimentalities. The question is rather one regarding the duties of different agents in relation to the dire health situation of the global poor, and of the rights of those in that situation.

1.3.3. Objection Three: The Insufficiency of Basic Needs

Griffin's third attack against the basic needs account points out that 'the needs account is not rich enough'[106] - meaning insufficient for justifying human rights. The reason, he states, is that the needs account only justifies human rights protection up to the insufficient limit of 'subsistence' (i.e. minimally decent human existence). Griffin's third

[106] Ibid, p.53

objection actually builds on the second – i.e. the fact that the basic needs account does not include 'informed-desires' when stipulating what is 'important, vital and urgent'. This same fact, according to Griffin, makes the basic needs account insufficient to justify human rights. Human rights, for him, serve the precise purpose of protecting 'the agency involved in living a worthwhile life'—what he calls 'normative agency'[107]. And this is the reason why he suggests complementing the basic needs account with the idea of 'normative agency' to compose his personhood account of human rights:

> The personhood account generates a positive right to the minimum provision necessary to support life as a normative agent, which is substantially more than just subsistence […] My account can therefore be seem as a kind of need account: what is needed to function as a normative agent […] There will clearly be great overlap between the lists that emerge from these two accounts […] But the lists will not be the same. The personhood account is more focused and exclusive in the role it specifies: what is needed to function as a normative agent.[108]

So, for Griffin, the problem of the basic needs account is that it is not a 'rich enough' account of human rights, because it excludes from human rights protections morally relevant 'informed desires' that are indispensible for the exercise of 'the agency involved in living a worthwhile life' (i.e. 'normative agency')[109].

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[107] Griifin, 2008, p.45

[108] Ibid, p.90

[109] Ibid, p.45

The Problem: The baseline or threshold of subsistence

The actual problem with the basic needs account, for Griffin, relates to where the baseline or threshold dividing what deserves human rights protections, and what does not, lies. According to Griffin, there are two main problems associated with the basic needs baseline or threshold of 'subsistence'. On the one hand, the basic needs account is not inclusive enough: as I have discussed above, it is problematic for Griffin's purposes, because it excludes certain prudential values (i.e. informed-desires) from the scope of human rights protections. On the other hand, as Griffin claims, the basic needs account is not focused or specific enough to inform a plausible protection of human rights: in this regard, Griffin criticizes the basic needs account's key concepts of 'ailment,' 'malfunctioning,' and 'harm' for being so broad that they result in 'implausibly lavish' demands. These are actually two different issues, but Griffin conflates both, by addressing them together under his claim of the insufficiency of the basic needs account as the proper ground for human rights. He writes:

> If we were to have a human right to anything needed to avoid ailment and malfunction, then human rights would be in danger of becoming implausibly lavish. I could then demand by right that society devote resources, if it had them, to curing any ailment I had, however slight, and correcting any malfunction I experienced, however unimportant. But nearly everyone accepts that, on the contrary, there comes a point where ailments and malfunctions become minor enough that they do not create, by right, a demand upon others to remedy them […] I have mentioned ailment and malfunction, which are only two of the three terms I used earlier to define 'basic' human needs. The third is 'harm', which has

> more breadth, so perhaps more promise, than the first two. A basic human need, one could say, is what is needed to avoid harm. But that too, is not enough.[110]

In brief, Griffin is saying that the basic needs account is insufficient not only to justify the required minimum of the protection of human rights, but also the plausible maximum to it. His proposed solution then to the two forms of insufficiencies (namely those related to the minimum and those related to the maximum level of protection) regarding the basic needs threshold is the more inclusive, yet more precise threshold of 'the worthwhile life of the normative agent'. For Griffin, only the personhood account of human rights, which adds the idea of 'informed desires' and thereby allows normative agents to lead a worthwhile life, will be able to provide the right scope of human rights protection, with enough precision on what counts as a relevant value for protection, and what does not. Griffin argues that the basic needs account does not provide enough guidance both in terms of what counts as minimal, and in terms of what counts as maximal limits of protection.

First, with regards to the minimal, as I have argued above, even if one agrees with Griffin that the basic needs account does not provide a complete baseline or threshold to fix the minimum degree of normative protection, and that 'informed-desires' shall also be taken into consideration in the processes of designing health policies, that does not invalidate my original argument: basic health needs still have relevance as a distinguished category from non-basic health needs, since it provides a *prima facie* moral reason in favor of prioritizing them over non-basic health needs *ceteris paribus*, and it refers to matters that are of the most stringent and important requirements of justice. As argued

[110] Ibid, pp.89-90.

above, there is nothing in my argument that entails that basic health needs have to be the single moral criterion and determinant reason in all cases in order to prove its relevance and applicability. Griffin simply demands too much of the idea of basic needs, but it does not need to do all the moral work he expects it to do (and that he argues it fails to do), to be a useful moral concept—and, in particular, to be useful for the purposes of analyzing the moral requirements at stake in the GHC.

Furthermore, Griffin's account does not completely deny the minimum threshold provided by the basic needs account. Instead, he complements the basic needs account's purported insufficiency by building on its minimum threshold, and adding onto it his idea of 'informed-desires'. Griffin in actuality disagrees with the precise location of the threshold. For Griffin, the threshold should be placed higher: given that survival/minimally decent life provides too little protection, the right amount is above it, precisely at the level of protection necessary to ensure a 'worthwhile life'. Again, disagreement on precisely where the minimum threshold of human rights protection should lay does not defeat the basic needs account as a whole, nor does it defeat my initial argument. If basic needs pointed to a lower threshold of protection than should be the case for human rights, this would not deny that marking the threshold at the point at which basic needs does is of no relevance. It would still be of relevance, for example, if we are interested in distinguishing more severe failures to meet human rights' standards from less severe failures to meet said standards.

Second, with regards to the maximal limits of human rights protection, Griffin claims that the basic needs account does not provide enough precision that allows differentiating and then discarding those claims that are 'too lavish'. Above I have argued against the well-being conception of health, and I have said that, precisely because it is too

encompassing, this conception of health conflates two different moral categories that give rise to different duties of justice, with different stringency. Griffin is saying, however, that the basic needs account has exactly the same problem that I said the well-being account has: it is 'too lavish', and as such, it would be undifferentiated.

There is nevertheless nothing in Griffin's claim that defeats my argument against the well-being conception of health and the need for a differentiation between what is basic and non-basic within the realm of health rights and duties. In actuality, Griffin would agree with my points against the well-being conception of health. First, Griffin explicitly states that 'health is not equivalent to "well-being", although the WHO, in the Preamble to its Constitution, in effect declares that it is'[111]. Second, and more importantly, Griffin explicitly disagrees with the conception of health purported and repeated by international documents, which I am calling the well-being conception of health. He remarks that

> [t]he International Covenant on Economic, Social and Cultural Rights of the United Nations, followed by many other international documents, announces that we have a human right to "the highest attainable standard of physical and mental health". But that cannot be so. The highest attainable standard of physical and mental health is not even a reasonable social aim, let alone a right.[112]

In brief, even if one agrees with Griffin that the basic needs account is not able to fix with enough precision where the maximal level of human rights protection should lie, Griffin's premises against the existing conception of the human right to health as a right to the

[111] Ibid, p.101

[112] Ibid, p. 99

highest attainable standard of physical and mental health matches with our premises, in turn, showing themselves to be against the well-being conception of health too. There is nothing in Griffin's claim against the inability of the basic needs account in fixing the maximum that defeats my original argument for the need to differentiate basic and non-basic health needs as different moral categories purporting different requirements of justice.

Griffin's proposed solution: adding richness and precision through informed-desires

How does Griffin propose to make a richer, yet not 'implausibly lavish' account of human rights? As discussed above, Griffin argues that while the basic needs account with the idea of survival (i.e. minimally decent human existence) is too little, he also acknowledges that the well-being account with the idea of a fully flourishing life is too much. Griffin's proposed solution will be somewhere in between. Here, I am interested with his conception of the human right to health. On Griffin's personhood account, the human right to health will go beyond the protection of the basic health needs required for mere subsistence; yet it would not go as far as claiming a right to a state of full well-being, which no one can be obliged to achieve:

> There must be a point, we all agree, at which the moral demands of health are fully met and beyond which we are not obliged to go. There must also be a point at which the demands of health, although not fully met, are so little affected that they matter less than some mere desire.[113]

[113] Griffin, 1986, p.52

But the problem, as he poses, is, 'how do we decide where these points are?'[114] The answer to the question on where the adequate baseline/threshold lies, according to Griffin, is therefore given by his personhood account on human rights, which gives the right measure of protection. According to the personhood account of human rights, the right to health protects those human functions necessary for the exercise of normative agency. No more, and no less: for Griffin, only those illnesses impairing the normative agency are an object of human right protection. The other illnesses that do not prevent individuals from exercising their normative agency will not be a matter of concern for human rights: as illnesses, they will have to be treated, and thus will be a matter of medical concern, but they will not, according to Griffin's account, be a matter of human rights concerns. As he argues:

> What is the right to health a right to? There are many forms of ill health that do not jeopardize normative agency. We all get sniffles from time to time. The sniffles are pathological; they are illnesses. But they do not stop us from being agents. According to the UN, we have a human right to have these sniffles treated; according to the personhood account, we do not.[115]

Griffin's personhood account gives a very specific scope of application for the human right to health: the right to health, on the personhood account, provides protection only to those specific human functions that are necessary for the exercise of normative agency. As he puts it:

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[114] Ibid, p.52
[115] Griffin, 2008, p.101

> On the personhood account, we have a right to life, because life is a necessary condition of normative agency. And on the personhood account we also have a right to the health support necessary for our functioning as normative agents […] Protecting normative agency requires protecting certain human capacities: namely, those without which one's options in life shrink so drastically that life as a normative agent is undermined. Life as a normative agent requires a reasonable span of life and level of health.[116]

This is the exact purpose of the human right to health for Griffin: it protects and ensures our functioning as normative agents, so that we may be able to autonomously choose and freely pursue lives worthwhile living, during a reasonable span of time, and with a reasonably good quality of life. Griffin gives the example of 'the crippled' person, who, being a 'bearer of rights', has the right to claim the provision of special access to public buildings, so that he may have equal opportunities to exercise his capacities as a normative agent[117].

Griffin's personhood account of human rights is controversial: he explicitly excludes from the human rights protection realm all those who are not normative agents. As he argues, 'only normative agents bear human rights – *no exceptions*: not infants, not the seriously mentally disabled, not those in a permanent vegetative state, and so on.'[118] Griffin contentiously claims that 'infants', 'the seriously mentally disabled', and 'those in a permanent vegetative state' are not human rights holders, and therefore are not

[116] Ibid, pp.100-101

[117] Ibid, p.68

[118] Ibid, p.92

protected by human rights -- although they might be protected by others spheres of morality[119]. I do not need fully to engage with and refute Griffin's views on his selected human rights holders in order to maintain my original argument in favor of the basic needs account and the normative relevance for differentiating between basic and non-basic health needs. There is nothing in Griffin's controversial definition of human rights' holders that undermine my argument in favor of a minimalist conception of health, as opposed to the well-being conception of health – which Griffin also opposes.

Conclusion

In this chapter, I have argued for a more differentiated conception of health, which can better cope with the more concrete requirements of justice as applied to the right to health. If the most basic health needs will presumably be associated, *ceteris paribus,* with more stringent requirements of justice, then the practical debate about creating institutions which further specify the right to health must be attentive to a more discriminate, and more accurate, definition of health. I have argued against the current conception of health, which equates it to the all-encompassing idea of well-being. This conception is problematic because it is too undifferentiated for the practical purposes of global institutions allocating health-related responsibilities. The well-being conception of health conflates basic and non-basic health needs, more stringent claims and less stringent claims. This conflation obscures key normative differences, and as such is an obstacle to any progress on health-related political discussions and negotiations. The purpose of this chapter has been to raise awareness of this normative differentiation and to illuminate a particular shortcoming of the current definition employed by international

[119] Ibid, p.95

human rights legislations, and echoed by global, regional, and domestic institutions and authorities dealing with a right to health and its practical dilemmas.

Chapter 2 – The Human Right to Health and its corresponding responsibilities

In this chapter, I will introduce the debate on the different duties[120] arising from the right to health; I will show one specific point upon which the different views agree, and discuss some implications regarding this consensus or common ground. Consensus is relevant for the purpose of crafting workable institutions. Therefore, the common ground is important for the purposes of constructing an argument that is not only theoretically reasonable but also politically workable, and thus worthwhile for both academic and practical purposes. I will focus solely at the global level of the debate, rather than at the national level pertaining domestic legislations and national courts, since only the former is relevant for the argument of this thesis.

In section 2.1, I will give a brief explanation of how the right to health has been understood in international law. I pay particular attention to UN documents, since the UN is the institution responsible for providing the initial concept and specification of human rights at a global level, including the right to health. Particularly, when it comes to the right to health, the UN has been prolifically advocating various specific duties in correlation to its 'well-being conception of health' (in the sense I explained in chapter 1).

These duties that the UN documents advocate are contentious, as we shall see, not only within the UN itself. I will discuss in section 2.2 how John Ruggie and Paul Hunt, two UN independent experts, disagree even on the nature and content of some general responsibilities. I will also discuss, in section 2.3, the scholarly debate among

[120] I will use the words 'responsibility', 'duty', and 'obligation' interchangeably.

philosophers regarding the duties correlated to the so-called Economic, Social and Cultural Rights (ESCR), which includes the right to health.

As contentious as the right to health and its corresponding duties may be, I will show in section 2.4 that all the different authors and institutional actors debating the right to health and its possible corresponding duties agree at least in this aspect: there is a negative responsibility to respect the right to health. I will argue that this is the common ground in this debate, and I will here explore the limits and content of this consensus, particularly in the context of the GHC. I will argue that the responsibility to respect the right to health is two-fold, as it yields a further specification of: (i) a duty to avoid infringing the human right to health of others, by imposing, maintaining or creating institutions that generate an avoidable insecurity of access to basic health needs; and (ii) a duty to remediate violations of the previous duty. In the next chapters, I will explore the responsible agents for this common ground duty (chapters 3 and 4) and how it may be institutionally enforced (chapter 5).

2.1. The Human Right to Health in International Law

What is the human right to health? In the previous chapter, I discussed the moral value of health, and I argued that basic health needs have a distinct moral relevance. Here, I will further discuss the idea of basic health needs and argue that it provides strong enough moral justifications to create rights with corresponding duties for the legal protection of the basic health needs of all.

International documents advocate what I called in chapter 1 ‘the well-being conception of health’, and I have argued that it obscures the morally relevant issues at stake, by

conflating under the same label of "well-being' very stringent requirements of health with other matters that would be simply desirable, or even a luxury. Different rights and duties are related to these different aspects of health – namely the aspects related to basic health needs, and the aspects related only to well-being generally. In this thesis I focus on the former because this concept captures the stringent requirements of health, which are those are those at stake in the GHC, and which have higher priority over all other non-basic health needs.

The stringent moral force of basic health needs justifies the establishment of certain rights with corresponding duties for their satisfaction. What are rights? It is not necessary to provide here a full account of the concept of rights[121], but only to point to some generally accepted characteristic features of rights. Rights are not mere desires or wants, nor are they mere interests that can be chosen by each individual in the pursuit of his own aspirations; rights are not just collective goals either. Rights have a distinct moral force: they have preeminence over other considerations[122]. Rights have to do with justice and responsibilities[123]: they express what we owe to others with whom we, in

[121] For a general account of rights see Eleftheriadis, *Legal Rights*, 2008, especially chapter 1, where he discusses the three main accounts of rights: (i) the Hohfeldian account and the 4 types of rights: claim-rights, liberty/privilege, power, and immunity; (ii) the will or choice theories, put forth by Kant and Hart; and (iii) the interest/benefits theories, put forth by Bentham and Raz.

[122] This preeminence can be expressed in different ways: Waldron, 'The Primacy of Justice', in *Legal Theory*, 9, 2003, pp.269-294, gives three examples of how this preeminence is expressed: rights as "trumps" (Dworkin), rights as side-constraints (Nozick), or rights as having 'lexical-priority' (Rawls).

[123] I am aware of the debate contending that rights and duties do not necessarily correlate. One example of this position is Raz ('The Nature of Rights', in *The Morality of Freedom,* 1996, pp.184-6), for whom rights and duties are not necessarily correlated, and rights take precedence over the duties they ground. Another example is Griffin (2008) discussed at length in chapter 1. I will here, nevertheless, assume and follow the well-established view on the necessary link between rights and duties.

some way or another, *relate* – rights, justice and responsibilities are therefore *relational* concepts[124].

Some rights are 'human rights'. The idea of a human right is a contested one[125], but it is commonly accepted that they are rights held by every member of the human species just by virtue of being human. In this vein, there is a human right to health. It is first and

[124]Justice, rights and responsibilities are interlinked concepts: they all have to do with relationships. In other words, they all have to do, first and foremost, with our conducts (i.e. actions and interactions, in our different communities), rather than 'items that can be possessed' (O'Neill, 2000, p.98), or a mere fixed list of political goals and outcomes that can be achieved (Eleftheriadis, 2008, particularly chapter 6, where he defines legal rights as clusters of legal relations among persons.) On the relational aspect of the right to health care, see: Eleftheriadis, 'The Right to Health Care', in *Journal of Law, Medicines & Ethics*, 40:2, 2012, 268-285, p.278.

Surely, the object of certain rights -- particularly ESCR, as I will discuss in this chapter – is certain basic goods and services, and secure access to them ought to be provided. Nevertheless, ESCR are 'claim rights, which mirror certain sorts of obligations: both claim rights and the corresponding obligations are a matter of required types of action, or of omission'. (O'Neill, 2000. p.98)

[125] Rawls (*The Laws of Peoples*, 1999, p.65) provides a list of Human Rights, comprising only the following rights: life (protecting the means of 'subsistence' and 'security' – Rawls therefore explicitly builds on Shue's theory of Human Rights), liberty, property, and formal equality. He does not explicitly mention freedom of expression or assembly or political participation or religious freedom, nor does he mention education or health. He mentions, nevertheless, a right to subsistence, which is related to the right to life. As Rawls conceives human rights, these are rights that inform the political morality within the relations between political communities (i.e. peoples). Accordingly, human rights are first and foremost norms of protections within the domestic realm; and only the violation of human rights can sufficiently justify coercive interventions by other governments (i.e. other liberal and decent peoples).

Beitz seems to build on Rawls' conception of human rights as principles of justice that justify international interventions in the case of human rights threats and violations. He writes: 'Human Rights are standards for law and public policy whose breach on a sufficient scale constitutes a *pro tanto* justification of remedial international action' (Beitz, 'Human Rights and the Law of Peoples', in Chatterjee*, The Ethics of Assistance: Morality and the Distant Needy,* 2004, p.208)

Sen and Nussbaum put forth the idea of human rights as human capabilities. Ruger (*Health and Social Justice*, 2010) builds on the capabilities approach to define the right to health care.

Griffin and Tasioulas build on Raz's interest theory of rights. While Griffin conceives human rights according to his personhood account (*On Human Rights*, 2008) as discussed at length in chapter 1, Tasioulas puts forth his pluralistic account ('The Moral Reality of Human Rights'*,* in Pogge, *Freedom from Poverty as a Human Right – who Owes What to the Very Poor?,* 2007, p.94) that is context-sensible and indeterminate, because of the 'dynamism of rights and duties', which change and vary depending on the context.

Daniels (*Just Health – Meeting Health Needs Fairly*, 2009), and Buchanan (*Justice and Health Care*, 2009) justify human rights and the right to health in particular based on the Rawlsian idea of procedural criteria and a fair and legitimate process in the allocation of health care resources, in order to identify a minimum threshold of protection. Yet, while Daniels explains the allocation of health care resources based on a principle of fair equality of opportunities (i.e. a fair share of the normal range of opportunities), Buchanan argues for a pluralistic basis for a legal entitlement to a decent minimum of health care, to be defined and allocated through collective choices of legitimate political process.

foremost a universal moral right: the right to health is a universal right possessed by all human beings, and owed to all human beings, simply in virtue of their shared humanness and vulnerabilities. It is also a legal right, recognized and posited in various legal instruments, not only at the international realm (in both customary and codified International Law), but also in domestic jurisdictions (in various national constitutions and legislations)[126].

It is debated whether human rights impose only basic requirements, or impose more broad and general requirements beyond basic and stringent duties of justice. Here, I focus on the basic aspect of the right to health, i.e., on health as a basic human right. As Shue puts it:

> Basic rights are everyone's minimum reasonable demands upon the rest of humanity. They are the rational basis for justified demands the denial of which no self-respecting person can reasonably be expected to accept. Why should anything be so important? The reason is that rights are basic in the sense used here only if enjoyment of them is essential to the enjoyment of all other rights. This is what is distinctive about a basic right.[127]

According to Shue, a basic right is 'basic', in two ways: (i) it establishes the minimum threshold of protection of certain common goods (that are the objects of the right under

[126] On human rights as being primarily moral rights, see Tasioulas (2007). On human rights as being moral rights as well as legal rights with corresponding legal obligations that depend on executive, legislative, and judicial institutions to specify their content and to impose them, see Pogge, *World Poverty and Human Rights – Cosmopolitan Responsibilities and Reforms*, 2002, pp.52-70; and Pogge, *Politics as Usual*, 2010, pp.26-56.

[127] Shue, 1980, p.19

concern); and (ii) its realization is basic to the realization of all other rights. In this sense, the right to health is a basic right, because (i) its object – the basic health needs – establishes the minimum threshold of protection and promotion of the good of health necessary for a minimally decent human existence; and (ii) its object – the basic health needs — is essential for the exercise of all other rights.

As well as being a basic moral right, the right to health is also a recognized basic legal right: it is posited in various international law instruments as well as in various national constitutions worldwide. The legal human right to health, as with all legal human rights, is an attempt to give recognition in the law to moral human rights, so as to promote its actual realization through the law. The idea of 'legal rights' is also a contested one, but it is generally uncontroversial[128], and it was presupposed in the enactment of at least the most paradigmatic bills of rights that legal rights have a reason or justification -- they are not arbitrary – and their justification appeals to moral rights. In this thesis, I will focus only on the international domain, and in this chapter I will focus mainly on the UN documents that set the ground for an initial understanding of the legal human right to health and its corresponding duties to be specified by domestic legislations and national courts, and on the normative debates regarding which understanding of the human right to health and its duties is more faithful to moral rights.

The human right to health is recognized within the UN as an 'economic, social and cultural right', and it was posited in the Bill of Rights, which comprises the UDHR, the International Covenant of Civil and Political Rights (ICCPR), and the ICESCR. The

[128] With the exception of some utilitarians, such as Bentham, who thought that the idea of rights was "nonsense upon stilts", unless it was grounded in the principle of utility. In this sense, Bentham was particularly critical of natural rights, and by extension human rights.

human right to health was first recognized in 1948 by the article 25.1 of the UDHR, and was then posited in 1966 by the article 12 of the ICESCR. In 2000, the UN Committee on Economic, Social, and Cultural Rights issued the General Comment 14, which is the first and the main document that provides a more thorough idea on the right to health and its corresponding duties[129].

The General Comment 14 builds on the early conceptions of the right to health provided by the Bill of Rights. It is recognized as the chief document on the content of the right to health and its correlated duties, whose fulfillment is expected from states and also from the international community as a whole. Although only states are parties of the ICESCR on which the General Comment 14 provides comments, and, therefore, although the General Comment 14 mentions only 'states duties' throughout its text, this does not preclude the responsibilities of other global players. Quite the contrary: the General Comment 14 clearly mentions that all the members of the international community (state and non-state actors alike, with an explicit mention of 'the private business sector') 'have responsibilities regarding the realization of the right to health'[130].

When it comes to the responsibilities correlated to the right to health, the General Comment 14 first clarifies that the right to health requires the duty of 'progressive

[129] UN.Doc.E/C.12/2000/4, 2000

The UN human rights treaty bodies (including the UN CESCR publish their interpretation of the content of human rights provisions, in the form of 'General Comments' on thematic issues. In this respect, the General Comment 14 of the UN Committee on Economic, Social, and Cultural Rights interprets the content of the human right to health.

[130] See particularly paragraph 42: 'While only states are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore, provide an environment which facilitates the discharge of these responsibilities. (UN.Doc.E/C.12/2000/4, 2000, para 42)

realization', rather than a 'full immediate realization'[131]. The General Comment 14 explains in its article 30 that the duty of 'progressive realization' is a 'general legal obligation' that comprises 'the obligation to take steps (article 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health'.

The General Comment 14 also mentions a number of other 'legal obligations'[132] as well as certain 'minimum core obligations'[133] correlated to the right to health. In essence, the General Comment 14 echoes the familiar UN parlance on the tripartite responsibilities for human rights: the duties to respect, to protect, and to fulfill. The tripartite typology of human rights responsibilities was first conceived by Shue[134] in the 1980's; it was then fully incorporated into the UN parlance by Asbjorn Eide in 1987, at the former Special Rapporteur on the Right to Food[135], and ever since has been reiterated by most UN documents, including those related to the right to health. As Shue puts it: 'for every basic right there are three types of duties, all of which must be performed if the basic right is to be fully honored but not all of which must necessarily be performed by the same

[131] See Hessler and Buchanan, 'Specifying the content of the right to health care', in Buchanan, *Justice and Health Care*, 2009, pp.203-218.

[132] UN.Doc.E/C.12/2000/4, 2000, Articles 30-42

[133] UN.Doc.E/C.12/2000/4, 2000, Articles 43-45

[134] Shue, 1980

[135] See UN.Doc.E/CN.4/Sub.2/1987/23, *The Right to Adequate Food as a Human Right*, 7 July 1987, para.66-69.

individuals or institutions.'[136] Basic rights, including the human right to health, therefore, yield a range of duties, which Shue and the UN classify into three main groups[137]:

(i) The *responsibilities to respect*, which require that agents 'avoid depriving other of their rights'[138]. The General Comment 14 puts it in this way: 'The obligation to *respect* requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health'[139]. The responsibility to respect the right to health requires that duty-bearers refrain from interfering with the right to health of others, by avoiding depriving them of their basic health needs. In other words, the responsibility to respect the right to health of others requires that duty-bearers do not violate the right the health of others.

(ii) The *responsibilities to protect from deprivation*, which require the duty-bearer to protect right-holders from third parties whose conducts may cause deprivation of a right. The responsibility to protect from deprivation, as Shue explains it, encompasses not only a duty to enforce the responsibility to respect, but also a duty to design institutions that prevent deprivation[140]. The General Comment 14 explains the responsibility to protect as follows: '[t]he obligation to *protect* requires states to take measures that prevent third parties from interfering with

[136] Shue, 1980, p.52

[137] Shue first conceived the tripartite typology in 1980 in the following terms: "with every basic right, three types of duties correlate: (i) Duties to *avoid* deprivation; (ii) Duties to *protect* from deprivation; (iii) Duties to *aid* the deprived. Later, in 1987, Eide reshaped Shue's original model, introducing within the UN the familiar 'Respect, Protect, and Fulfil Framework of Human Rights Responsibilities'.

[138] Shue, 1980, p.53

[139] UN.Doc.E/C.12/2000/4, 2000, Art.33

[140] Shue, 1980, p.53

article 12 [on the essential elements of the right to health] guarantees'[141]. Accordingly, I will here consider that the responsibility to protect the right to health requires duty-bearers to prevent third parties from interfering with the right to health of others, by allowing third parties to deprive right-holders of their basic health needs. In this vein, for example, governments – considered the primary, but not exclusive, duty-bearers of the right to health of their citizens – have the duty to prevent others from violating the right to health of their citizens. Governments have in this regard, for example, the duty to adequately regulate their national health care system and its providers; they also have a duty to enforce said regulations by establishing proper legal/judicial institutions[142].

(iii) The *responsibility to fulfill*, which requires duty-bearers to 'aid the deprived'[143]. As the General Comment 14 puts it: '[t]he obligation to *fulfill* requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health'[144]. Accordingly, I will here consider that the responsibility to fulfill the right to health requires duty-bearers to aid all those who are deprived of their Basic Health Needs. This may entail, for example, that a certain government may be responsible for making

[141] UN.Doc.E/C.12/2000/4, 2000, Art.33

[142] On the responsibility to protect and more specific examples of the state's duty to prevent and regulate, see Wolff, *The Human Right to Health*, 2012, p.88

[143] The responsibility to aid the deprived, as Shue explains it, can encompass at least 3 sub-categories of duties to aid, depending on who is deprived: (i) the duty to aid the deprived who has a special relationship with the duty-bearer (like the duty of parents to their child; or the duty of a national government to its own citizens); (ii) the duty to aid the deprived whose deprivation has been caused by a social failure in the performance of the aforementioned duties (the duty of international solidarity – meaning the duty to aid the non-national deprived – can be an example here because it arises from a failure of the government's responsibility to respect and protect the rights of its own citizens, who now, being deprived, have the right to receive aid from the international community); and (iii) the duty to aid in case of natural disasters (these are the so-called duties of humanitarian assistance). (Shue, 1980, pp.56-57)

[144] UN.Doc.E/C.12/2000/4, 2000, Art.33

> available and providing a certain medical treatment for their population. Obviously, the actual provision of medical treatments depends on multiple factors and constraints – the financial limitations of each government's budget are a clear example. Nevertheless, this difficulty does not provide a reason to dismiss the responsibility to fulfill the right to health, but rather to satisfy it to the greatest extent possible, giving a special priority to the satisfaction of basic health needs.

In sum, the duties to respect, protect and fulfill the right to health are recognized and posited in the international law of human rights. Nevertheless, their precise scope and content spur protracted debates both within the UN and among theorists. I will first discuss the matter of controversy within the UN, between the two UN independent experts dealing with these questions – Ruggie and Hunt, and then I will explain the theoretical disagreements on the nature of the duties correlated to ESCR, which includes the right to health, by discussing the different views of Onora O'Neill, John Tasioulas, and Thomas Pogge.

2.2. The Controversy Within the UN - Ruggie vs Hunt

Professor Ruggie of Harvard University was appointed as the 'Special Representative on the issue of Human Rights and Transnational Corporations' in 2005 by Kofi Annan, UN Secretary-General at the time; his mandate was then extended by current Secretary-General Ban Ki-moon until 2011. The mandate aimed 'to move beyond what had been a long-standing and deeply divisive debate over the human rights responsibilities of companies' and to build a 'meaningful consensus among all stakeholders about the roles and responsibilities of both states and companies with regard to business's impacts on

human rights'[145]. In order to achieve these aims, Ruggie conducted extensive research and convened several consultations with relevant stakeholders – i.e. global players.

In 2008, Ruggie proposed a basic framework for the business and human rights debates to the UN HRC. His 'conceptual and policy framework'[146] in essence comprise three core ideas that follow Shue's tripartite classification of human rights' responsibilities: (i) the corporations' *responsibility to respect* Human Rights; (ii) the state's *responsibility to protect* against third parties' abuses, including businesses; and (iii) the responsibility to provide access to effective remedy, both judicial and non-judicial, for victims of abuses.[147] The 'Protect, Respect and Remedy Framework' as it is known was then 'unanimously welcomed'[148] by the UN HRC. In 2011, by the end of his mandate, Ruggie wrote a last report to the UN HRC, the *UN Guiding Principles on Business and Human Rights*[149], where he reiterated and further explained his proposal. The UN HRC 'unanimously endorsed'[150] Ruggie's *UN Guiding Principles on Business and Human Rights* for implementing the 'Protect, Respect and Remedy Framework', as it provided 'for the first time – a global standard for preventing and addressing the risk of adverse

[145] For further details on the mandate see: http://www.ohchr.org/EN/Issues/Business/Pages/SRSGTransCorpIndex.aspx

[146] 'This report presents a conceptual and policy framework to anchor the business and human rights debate, and to help guide all relevant actors.' (UN.Doc.A/HRC/8/5, Ruggie, *Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises – Protect, Respect and Remedy: a Framework for business and human rights*, 7April2008).

[147] UN.Doc.A/HRC/8/5, Ruggie, 2008.

[148] http://www.ohchr.org/EN/Issues/Business/Pages/SRSGTransCorpIndex.aspx

[149] UN.Doc.A/HRC/17/31, Ruggie, *Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises – Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework*, 21March2011.

[150] http://www.ohchr.org/EN/Issues/Business/Pages/SRSGTransCorpIndex.aspx

impacts on human rights linked to business activity'[151]. Ruggie's *UN Guiding Principles on Business and Human Rights* are an original set of recommendations, showing (i) what steps business corporations should take to respect human rights; (ii) what steps states should take to promote business respect for human rights; (iii) what steps stakeholders in general (i.e. the international community as a whole) should take to reduce the risk of causing or contributing to human rights harm, and to assess and redress business respect for human rights. This is the basic outline of Ruggie's 'Protect, Respect and Remedy Framework'[152].

For Ruggie, while states have full obligations to respect, protect, and fulfill human rights, corporations have merely the responsibility to respect human rights. Ruggie clarifies his conception of the corporate responsibility to respect human rights: First, Ruggie affirms that the corporate responsibility to respect is 'the baseline expectation for all companies in all situations'[153]. Second, Ruggie explains that the corporate responsibility to respect human rights 'means that they should avoid infringing on the human rights of others and should address adverse human rights impacts with which they are involved'[154]. Third, he remarks that this idea of respect as '"doing no harm" is not merely a passive

[151] http://www.ohchr.org/EN/Issues/Business/Pages/SRSGTransCorpIndex.aspx

[152] The main purpose of independent experts is highlighting situations of concern, bringing it to the attention of the international community, so that it can act accordingly. Their reports often provide a helpful analysis of particular human rights issues in a specific country or on a specific topic (such as business and human rights, or the right to health). The main purpose of the reports is to bring to the attention of the international community issues that are not adequately on the international agenda, and therefore help to shape future treaties and domestic legislations addressing these questions. (See: OHCHR, *Fact Sheet N.27: Seventeen Frequently Asked Questions about United Nations Special Rapporteurs,* p.12, http://www.ohchr.org/Documents/Publications/FactSheet27en.pdf). Accordingly, Ruggie's *Guiding Principles* and Hunt's *Guidelines* serve the main purpose of highlighting human rights issues related to the specific scope of mandates.

[153] UN.Doc.A/HRC/8/5, 2008, para.24

[154] UN.Doc.A/HRC/17/31, 2011, para.11

responsibility for firms but may entail positive steps'[155]. In other words, for Ruggie, the corporate responsibility to respect human rights encompasses both negative and positive duties. As an example, he adds: 'to discharge the responsibility to respect requires due diligence. This concept describes the steps a company must take to become aware of, prevent and address adverse human rights impacts'[156]. As part of the corporate responsibility to respect, the due diligence obligation includes several active or positive measures a company must take not only to become aware of, but also to prevent and to address human rights infringements: these might entail, *inter alia*, evaluating the human rights impact its business activities may have, and scrutinizing whether the firm is contributing to, being supportive of, or being complicit with human rights violations through their partnerships[157]. And fourth, 'the corporate responsibility to respect exists independently of states' duties'[158]. Surely, states and business corporations are two different global players, and it seems thus clear that businesses' responsibilities 'cannot and should not simply mirror the duties of states'[159]. For Ruggie, the corporate responsibility to respect is different to the state's responsibility to respect. It is also more restricted and specific than those responsibilities of the states[160].

Professor Hunt of University of Essex was the first specialist to be appointed as the 'Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable

[155] UN.Doc.A/HRC/8/5, 2008, para.55

[156] Ibid, para.56

[157] Ibid, para.56-81

[158] Ibid, para.55

[159] Ibid, para.53

[160] Ibid, para.60

Standard of Physical and Mental Health'. The UN Commission on Human Rights[161] appointed Hunt as an independent expert to examine and report back to the UN General Assembly on issues related to right to health violations worldwide. Hunt served between 2002 and 2008, when he handed his mandate over to Anand Grover.

In 2008, Hunt presented his final report to the UN General Assembly, where he set out his proposed *Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines*, after extensive research and several consultations with relevant stakeholders – pharmaceutical companies in particular[162]. In his guidelines, Hunt stressed that (i) 'access to medicines' is a 'vital feature of the right to the highest attainable standard of health'[163]; (ii) the international community – including the numerous international and national, state and non-state actors - 'share a responsibility

[161] The UN Human Rights Council replaced the UN Commission on Human Rights in June 2006, and it then mandated experts to study or continue studying particular human rights issues. This system of experts is better known as the Special Procedures system. The UN Office of the High Commissioner for Human Rights (OHCHR) gives technical support to special rapporteurs to undertake country missions; to act on individual cases and concerns; to send communications to states and other global players on alleged human rights violations or abuses; to conduct thematic studies and convene expert consultations; to engage in advocacy. Special Procedures report annually to the UN Human Rights Council and/or to the UN General Assembly. The specific tasks of each special rapporteur are defined in the resolutions creating or extending their mandates. For more details on the Special Procedures, see: http://www.ohchr.org/EN/HRBodies/SP/Pages/Welcomepage.aspx

[162] For a detailed background and drafting history of the *Guidelines*, see: Khosla and Hunt, *Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines – The Sexual and Reproductive Health Context*, in University of Essex – Human Rights Centre. Available at: https://www.essex.ac.uk/hrc/research/projects/rth/docs/Final_pharma_for_website.pdf

'Between 2003-2006, the Special Rapporteur engaged in many discussions on access to medicines with numerous parties, including pharmaceutical companies. These substantive discussions took place at symposia and workshops, as well as informal visits to pharmaceutical companies. They were informed by the work of states, pharmaceutical companies (and their associations, such as the International Federation of Pharmaceutical Manufacturers and Associations), United Nations Global Compact, OHCHR, WHO and other elements of the United Nations system, Business Leaders Initiative on Human Rights, numerous civil society organisations, and others. More recently, the Special Rapporteur has benefited from the reports of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises' (p.9).

[163] UN.Doc.A/63/263, Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 11August2008, Preamble d

to increase access to medicines'[164]; and (iii) amid the international community 'pharmaceutical companies, including innovator, generic and biotechnology companies, have human rights responsibilities in relation to access to medicines'[165].

What does Hunt precisely mean by 'human rights responsibilities'? When asserting that 'pharmaceutical companies have human rights responsibilities', what kinds of responsibility are these? Is it a baseline corporate responsibility to respect, as Ruggie suggests, or does it go beyond, and include corporate responsibilities to protect and fulfill human rights?

In this particular document, where Hunt provides guidelines to pharmaceutical companies, he does not rely on Shue's theoretical categories of human rights responsibilities (i.e. responsibilities to respect, protect, and fulfill) to specify the human rights responsibilities of pharmaceutical companies. This is because Hunt's *Guidelines for Pharmaceutical Companies* have a different purpose compared to Ruggie's *Guiding Principles on Business and Human Rights*. While Ruggie's *Guiding Principles* present 'a conceptual and policy framework to anchor the business and human rights debate, and to help guide all relevant actors'[166], Hunt seeks to provide a more practical and specific list of policy strategies that aim to clarify aspects that pharmaceutical companies should focus on when developing and implementing their own 'human rights policy

[164]Ibid, Preamble g.

[165] Ibid, 2008, Preamble i.

[166] Ibid, Abstract

statements.'[167] Hunt provides, in this regard, concrete guidelines that focus on specific matters such as transparency, management, monitoring, accountability, policy influence, patents, licensing, pricing, donations, ethical promotion and marketing. When comparing his own guidelines with Ruggie's *Guiding Principles*, Hunt remarks:

> Whereas [Ruggie's] *Guiding Principles on Business and Human Rights* are general human rights standards applicable to all business entities, the *Guidelines for Pharmaceutical Companies* identify with a greater degree of operational specificity: the human rights responsibilities of one sector (pharmaceutical companies) in relation to one area of sectorial activity (access to medicines).[168]

Though Hunt does not frame his proposal in terms of Shue's tripartite distinction of human rights responsibilities, it is possible to apply the tripartite distinction to his proposal so as to compare it with Ruggie's. Hunt does say explicitly that the responsibilities of pharmaceutical companies in relation to access to medicines 'encompass, but also look beyond, the corporate responsibility to respect'[169]. By saying this, Hunt is suggesting that his views on the pharmaceutical companies responsibilities for human rights have a broader scope than Ruggie's idea of corporate responsibility to respect. As Hunt writes:

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[167] 'The company should adopt a human rights policy statement which expressly recognises the importance of human rights generally, and the right to the highest attainable standard of health in particular, in relation to the strategies, policies, programmes, projects and activities of the company'. (Ibid, para.1)

[168] Lee and Hunt, 'Human Rights Responsibilities of Pharmaceutical Companies in relation to Access to Medicines', in *Journal of Law, Medicine and Ethics*, 40, Summer 2012, 220-33, p.224

[169] Ibid

> Having developed a life-saving medicine, the company has an additional human rights responsibility to take all reasonable steps to make the medicine as accessible as possible, as soon as possible, to all those in need. Of course, the responsibility is shared with states and others. The company is not expected to make the medicine immediately accessible to all those in need; analogous to a state's responsibility of progressive realization, the company has to move expeditiously and effectively, by way of deliberate, concrete, and targeted measures, to make the medicine as accessible as possible. What is required of the company is subject to its capacity; analogous to a state's responsibility to take steps "to the maximum of its available resources," more is required of a powerful transnational company with global networks than of a smaller business'.[170]

From this passage, we can infer that, in Hunt's views, pharmaceutical companies have not only a responsibility to respect the human right to health, but also the responsibilities to fulfill such right – particularly when it comes to a 'vital feature' of the right to health, namely access to medicine.

First, Hunt says that pharmaceutical companies have a 'human rights responsibility to take all reasonable steps to make the medicine as accessible as possible, as soon as possible, to all those in need'. This goes beyond the responsibility to respect. It falls into the categories of the duties to fulfill the right to health, that is, to 'adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards

[170] Ibid, p.228

the full realization of the right to health'[171]. Second, Hunt says that pharmaceutical companies' responsibilities are 'analogous to a state's responsibility of progressive realization' and 'analogous to a state's responsibility to take steps "to the maximum of its available resources"'. Here again, there is another indication that, in Hunt's views, the responsibilities of pharmaceutical companies go well beyond the idea of corporate responsibility to respect, and encompass the responsibilities to fulfill.

In sum, while for Ruggie, only states have full obligations to respect, protect, and fulfill human rights, and corporations have merely the responsibility to respect them, for Hunt, the corporate responsibilities of pharmaceutical companies are analogous to state's responsibilities - meaning that pharmaceutical companies bear responsibilities that go beyond respecting human rights: pharmaceutical companies also have responsibilities to fulfill human rights and in particular the right to health in. Nevertheless, both independent experts agree on the existence of one kind of responsibility for pharmaceutical companies, namely the responsibility to respect the human right to health.

There has not been much debate and engagement between the two independent experts. Hunt has only commented on Ruggie's *Guiding Principles on Business and Human Rights* in relation to his *Guidelines for Pharmaceutical Companies* once in a co-authored paper with Lee in 2012, and under a specific request of the editors. [172] In this paper, Hunt comments on Ruggie's *Guiding Principles*, and acknowledges that they share some common ground regarding the baseline corporate responsibility to respect. Yet, Hunt asserts the view that pharmaceutical companies have responsibilities beyond

[171] UN.Doc.E/C.12/2000/4, 2000, Art.33

[172] Lee, Hunt, 2012, p.228

the corporate responsibility to respect human rights, and in this paper the authors explore some of the dimensions of these responsibilities beyond respect.

In spite of possible further disagreements on the specifics of what the corporate responsibility to respect might entail, the two independent experts agree at least that pharmaceutical corporations have the responsibility to respect human rights, meaning: pharmaceutical corporations have a duty to 'avoid infringing on the human right to health of others and should address adverse human rights impacts with which they are involved'[173]. In the next section, I will discuss the further theoretical controversies around the duties correlated to the human right to health, so that we become better equipped to understand what the responsibility to respect exactly means, not exclusively in relation to pharmaceutical companies, but also to other global players that are relevant to the context of the GHC.

The responsibility to respect human rights -- including the human right to health -- is widely accepted both within the UN, as discussed in this section, and among philosophers, as I will discuss in the next section. If we take the UN concept of the corporate responsibility to respect, and apply it to other global players involved in the GHC, we will obtain that all persons -- including legal persons -- have a responsibility to respect the right to health of others, and this entails two things: (i) that we all have an *obligation to avoid infringing the human right to health of others*, and (ii) that we have an *obligation to redress adverse human rights impacts with which we are involved*.

[173] Ibid, p.228

In the particular context of the GHC, the responsibility to respect the right to health gives rise therefore, to these two sub-categories of the responsibility to respect: first, all global players (state and non-state actors alike, including individual persons, as well as legal persons such as pharmaceutical corporations), have an *obligation to avoid infringing the human right to health of others*; and second, all global players also have an *obligation to redress adverse human rights impacts with which global players are involved*. The *obligation to avoid infringing the human right to health of others* means that global players have the obligation to refrain from interfering with the right to health of others, by avoiding depriving them of their basic health needs. And the latter, *obligation to redress adverse human rights impacts with which global players are involved* means that global players have the obligation to remediate the negative impact on people's health arising from a violation to the duty of the first category.

2.3. The controversy Among Theorists - O'Neill vs. Tasioulas vs. Pogge

In this section of the chapter, I will continue to discuss the controversies arising from the duties correlated to ESCR, including the human right to health, in order better to understand what the responsibility to respect the right to health may further entail, especially in relation to its two sub-categories of duties mentioned above. I will argue for a negative responsibility to respect the human right to health because this is a widely accepted duty both within the UN, as discussed in previous section, and among philosophers, as I will discuss here.

ESCR are also referred to as 'welfare rights', and 'rights to certain goods and services')[174], and they are controversial, especially when it comes to specifying their correlated duties. O'Neill argues that, unlike civil and political rights, (CPR; also known as 'liberty rights') which ground only negative duties, ESCR ground both negative and positive duties. ESCR require institutions to implement the positive duties that ESCR ground. ESCR are thus institutionally dependent: without institutions that specify, allocate and enforce their counterpart duties, ESCR become mere 'aspirations'[175], 'mainly rhetoric, which proclaim "manifesto" rights against unspecified others'[176].

For O'Neill, 'rights must have well-specified counterpart obligations'[177]. As she puts it: 'both liberty rights and rights to goods and services are standardly seen as *claim rights* or *entitlements*'[178], which implies that there are correlative duties to those rights. But, as she argues, there is an 'asymmetry' between ESCR and CPR: in order to be claimable, welfare rights need institutions to define their corresponding duties, and to allocate them to specific duty-bearers[179]; liberty rights, on the other hand, can be claimable even in the absence of institutional mechanisms that allocate and specify their counterpart

[174] See O'Neill, 'The Dark Side of Human Rights', in *International Affairs*, 81:2, 2005, pp.427-39, p.427

[175] O'Neill, 2005, p.430, 434

[176] O'Neill, *Towards Justice and Virtue: A Constructive Account of Practical Reasoning*, 1996, p.132

[177] O'Neill, 2005, p.431

[178] Ibid, p.430

On the idea of 'claim rights', see also O'Neill, 2000, p.98. As she puts it: 'most important rights are intrinsically relational in that they are claim rights, which mirror certain sorts of obligation: both claim rights and the corresponding obligations are a matter of required types of action, or of omission'.

[179] O'Neill, 2005, p.429

obligations[180]. To explain this asymmetry, O'Neill gives the example of a universal right to food, and compares it to a universal right not to be killed or to speak freely:

> It is plausible to think that rights not to be killed or to speak freely are matched by and require universal obligations not to kill or not to obstruct free speech; but a universal right to food cannot simply be matched by a universal obligation to provide an aliquot morsel of food. The asymmetry of liberty and "welfare" rights, on which libertarians rest so much of their refusal to broaden their conception of justice, is, I think, well grounded.[181]

As Tasioulas remarks, these distinctions that O'Neill makes have to do essentially with 'the supposed distinction between negative liberty rights and positive welfare rights'[182]. Nevertheless, the distinction between positive and negative rights, as well as positive and negative duties, is not a clear one.

Firstly, some of the most basic duties corresponding to universal liberties are positive. The controversy within the theoretical realm seems to be now less heated, too, since it is now often assumed that each right gives rise to 'successive waves of duties', positive and negative alike[183]. As Waldron explains:

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[180] She states: 'the asymmetry between abstract liberty rights and abstract rights to goods and services is convincing: we can know who violates a liberty right without any allocation of obligation, but we cannot tell who violates a right to goods and services unless obligations have been allocated' (Ibid, p.428). See also O'Neill, 1996, p.131-134.

[181] O'Neill, 2000, p.135

[182] Tasioulas, 'The Moral Reality of Human Rights', in Pogge, 2007, p.90

[183] See Waldron, 'Rights in Conflict', in *Ethics*, 99:3, 1989, pp.503-519; p. 511; and Wolff, *The Human Right to Health*, 2012, p.30.

> we are unlikely to be able to sustain any simple division between negative and positive rights of the sort that liberals have often tried to work with […] A duty to refrain from interfering with someone's freedom is likely to be accompanied by a "positive" (and therefore costly) duty on other agents to protect people from such interference. And a duty positively to provide people welfare is likely to be accompanied by various "negative" (and thus relatively costless) duties on other agents to refrain from interfering with such provision if it is already underway. One and the same right may generate both negative and positive duties: some will require omissions while others will require actions and the expenditure of resources. […] Rights are to be thought of as generating not just one duty but successive waves of duties.[184]

In other words, Waldron is saying that both CPR and ESCR will equally generate various sorts of duties, negative and positive alike: universal liberties therefore, will also generate positive obligations, and welfare rights will also generate negative duties to refrain from interfering. For the former, take the example of the right to due process – a typical CPR: to comply with this right the state has the positive duty to implement institutions such as an independent judiciary, organs of prosecution that are separated from courts, legal counsel for those that cannot afford it, juries, etc. For the latter, take the right to be free from severe poverty: a basic duty required to ensure freedom from poverty is, as Tasioulas puts it, 'a duty not to obstruct others from certain activities that would enable them to secure the means of subsistence'[185], or, as Pogge puts it, 'a duty not to help uphold or impose social institutions under which [the global poor] do not have

[184] Waldron, 1989, p.511-512

[185] Tasioulas, 2007, p.90

secure access to the object of their human rights'[186]. A duty not to obstruct the secured access to the means of subsistence of others, or a duty not to help uphold or impose institutional barriers that hinder the secure access to the basic human needs of others are negative duties of non-interference. As Tasioulas acknowledges, these negative duties 'would have to be supplemented by positive duties to prevent such interference and to aid those who have suffered from its violation'[187]. Nevertheless, the same would apply to CPR: their counterpart negative duties will need to be supplemented by positive duties as well.

Furthermore, both ESCR and CPR ground negative duties, which will need to be supplemented not only by positive duties, but also by the institutions that will allocate and specify both kinds of duties. Contrary to what O'Neill suggests, I argue that negative rights and duties also need the legal specification that only institutions can provide. Surely, in some respects, the realization of a right is clear-cut and will not require further specification: the implementation of right not to be tortured, for example, is quite straightforward. Nevertheless, many rights require specification: the right to private property, for instance, cannot operate unless the state posits laws defining what this right is, how the ownership of an object is acquired, what the limits of private property are, etc.). In actuality, even the more clear-cut rights, such as the right not to be tortured, will only work to a limited degree without specification: it still needs legal specification for its full unfolding: the right not to be tortured requires further supplementations by criminal law institutions to define, for example, the punishment for

[186] Pogge, 2008, p.66

[187] Tasioulas, 2007, p.90

the torturer, the criminal procedure to disincentive the use of torture by officials, investigators, police, etc.

Since both CPR and ESCR ground negative as well as positive duties in order to be claimable and enforceable, the denomination of liberty rights as negative and welfare rights as positive is not an adequate one. This is not a matter of controversy within the UN anymore, where it is widely accepted that both CPR and ESCR depend equally on social institutions for their claimability and enforcement. In fact, Shue had himself emphasized, at the time the UN was incorporating his theory on human rights responsibilities, that the differences between negative and positive rights/duties was obscure, and should be regarded with doubt: the human rights responsibilities are interdependent[188], and thus equally spur positive and negative duties alike[189]. Shue's categories therefore, do not rely on the distinction between positive and negative, as all three of his categories of human rights responsibilities equally include both negative and positive duties[190]. Ever since Shue's clarification, the UN has dismissed these debates on the theoretical differentiations between positive and negative -- as I have examined in the previous section, both Ruggie and Hunt agree with Shue that the responsibility to respect entails both negative and positive duties[191].

[188] On the 'systematic interdependence of duties', Shue argues that 'a safe complete reliance upon duties to avoid is most improbable in the absence of at least minimal performances of duties to protect'. (Shue, 1980, p.61)

[189] Shue, 'The Interdependence of Duties', in Alston and Tomasevski (eds), *The Right to Food,* 1984, p.84; Shue, 1980, pp.35-64,153-66.

[190] As Shue puts it: 'Even the most basic liberty rights cannot be respected unless action is taken to set up institutions which secure them to prevent or restrain institutions and individuals which threaten liberty. Respect for all rights requires positive action as well as negative noninterference'. (1980, p.53)

[191] For Ruggie, see Doc.UN.A/HRC/8/5, 2008, para 55; For Hunt, see Lee, Hunt, 2012, pp.223-4.

Both policy makers and philosophers agree on the complexity of the division between positive and negative rights and duties, and on the interdependence of the duties to respect, protect, and fulfill. Nevertheless, it is still a matter of controversy which duties apply specifically to whom, and to what extent. While policy makers within the UN can only agree on the existence of a universal responsibility to respect ('universal' meaning applicable to all global players, state and non-state actors alike), philosophers can only fully agree on the existence of universal negative duties. Therefore, the only moral requirement that the different rapporteurs and theorists agree on is a negative responsibility to respect. This is the common ground.

It is consensual among policy makers, theorists, libertarians and all types of liberals alike, that, as a 'universal duty of justice'[192], the negative responsibility to respect ESCR (including the human right to health) and the legal institutions ESCR justify, have the primary purpose of securing 'the greatest liberty *compatible* with like liberty for all'[193], or in other words, equal freedom. This means that, as a 'universal duty of justice', the primary justification for the negative responsibility to respect the human right to health and for their enforcing legal institutions, is guaranteeing a legal order where all persons have equal and reciprocal respect for one another[194].

By saying that the negative responsibility to respect the right to heath first and foremost requires equal and reciprocal respect, I am saying that it requires first and foremost equality of respect, rather than equality of resources. This is a relevant consideration to

[192] For the definition of 'universal duties of justice' as 'universal principles of obligations', see O'Neill, 2000, pp.137-139

[193] O'Neill, 1989, p.194

[194] Ibid, p.194

be kept in mind throughout the following chapters, because all the discussions will be grounded on this premise (common ground) of equal respect, rather than equal resources (a very debatable form of equality, but frequently claimed by the mainstream right to health literature[195]). Surely, in order to specify certain duties deriving from the negative responsibility to respect the right to health and from its sub-categories – in particular the duty to remediate the GHC – a certain degree of redistribution of resources will be necessary to effectively address the GHC and its intrinsic global poverty-related inequalities. Nevertheless, the primary reason for and purpose of the remediation of the GHC is not redistribution of resources alone, or better distributional equality of health care resources per se. Rather, the primary reason is the rectification of the injustice of the GHC related to the violation of a right (i.e. the claim-right not to have one's secure access to its basic health needs infringed); and the primary purpose of the remediation of the GHC is the restoration of the equality of respect among all human beings. To be sure, the remediation of the GHC may entail some form of future redistribution of health care resources by the relevant institutions as a way of specification, allocation and enforcement of the negative responsibility to respect the right to health and its sub-category of duties; nevertheless this is a secondary and different question. The primary question is the rectification of the injustice inflicted amidst the GHC, primarily as a matter of equality of respect and freedom among all persons – this is the common ground, and it informs the consensus on the limitations of our responsibilities for the global poor afflicted by the GHC.

[195] See, for example, Daniels (2009) and Buchanan (2009), who justify human rights and the right to health based on the Rawlsian idea of procedural criteria and a fair and legitimate process in the allocation of health care resources, in order to identify a minimum threshold of protection. Yet, while Daniels explains the allocation of health care resources based on a principle of fair equality of opportunities (i.e. a fair share of the normal range of opportunities), Buchanan argues for a pluralistic basis for a legal entitlement to a decent minimum of health care, to be defined and allocated through collective choices of legitimate political process.

But why is a common ground important? Consensus is relevant for the purpose of crafting workable institutions. Therefore, the common ground is important for the purposes of constructing an argument that is not only theoretically reasonable but also politically workable, and thus worthwhile for both academic and practical purposes. It seems therefore reasonable to focus first on this broadly accepted type of responsibility, and see what this consensual responsibility entails, before proceeding with the more controversial questions regarding the other forms of responsibilities. I therefore want to start by exploring the common ground between the different positions, which will allow us later to establish which kinds of specific duties, institutions or policies should be acceptable to the main stakeholders in this debate. This strategy has also been adopted by Pogge who, rather than searching for a definite philosophical solution to the controversy over positive and negative rights and duties, bases his arguments on a widely accepted negative duty, in order to conceive an argument that is as widely acceptable as possible[196].

While Pogge is skeptical of the asymmetry and clear distinctions between CPR and ESCR, which O'Neill highlights[197], he would, nevertheless, agree with O'Neill's emphasis on the need for institutions to enforce and specify human rights. In order fully to understand Pogge's argument, we need first to discuss his institutional approach to human rights: how does Pogge conceive human rights and their corresponding responsibilities? Three considerations are relevant to understand his institutional theory:

[196] 'To keep my argument widely acceptable, I conceive human rights narrowly as imposing only negative duties […] And my argument can also be acceptable to those who endorse human-rights-imposed positive duties, because, by failing to invoke such duties, I am not rejecting them.' (Pogge, 2010, pp.28-29)

[197] Pogge, 2008, p.63,69

First of all, for Pogge, 'all human beings have exactly the same human rights'[198]. Human rights are in this sense universal: all human persons are equal subjects of human rights. And therefore, 'the moral significance of human rights and human-rights violations does not vary with whose human rights are at stake'[199].

Second, all human persons 'have certain basic needs, and these needs give rise to weighty moral demands. The object of each of these basic human needs is the object of a human right.'[200] So, each and every basic human need grounds a respective human right.

Third, Pogge's institutional account conceptualizes human rights as; special moral claims on the organization of a social institutional system. As he puts it:

> By postulating a human right to X, one is asserting that any society or other social system, insofar as it is reasonably possible, ought to be so (re)organized that all its members have secure access to X […] Avoidable insecurity of access, beyond certain plausibly attainable thresholds, constitute official disrespect and stains the society's human-rights record. Human rights are, then, moral claims on the organization of one's society.[201]

[198] Ibid, p.57

[199] Ibid,

[200] Ibid, p.58

[201] Ibid, p.64

For Pogge, a human right violation occurs when there is an avoidable insecurity of access to the object of that particular human right (i.e. basic human needs). As he puts it: 'Human rights are violated institutionally by those who make an *uncompensated* contribution to the imposition of social institutions that foreseeably give rise to an *avoidable* human-rights deficit' (emphasis added)[202]. Accordingly, from the duty not to violate human rights (meaning the duty not to infringe the secure access of people's basic human needs), there emerge two successive duties: (i) a duty not to impose or maintain or create avoidable insecure access to basic human needs; and (ii) a duty to compensate or remediate such violation. Both are interlinked because the latter only comes into play if the former is not satisfied.

Pogge argues, therefore, for an 'institutional understanding of human rights'[203], where he highlights the idea that human rights impose stringent duties to create, sustain, and reform institutions that have an impact on human rights. In essence, Pogge's institutional theory of human rights tries to justify our universal human rights responsibilities in terms of one basic negative duty: 'I must not help uphold and impose upon them [the global poor] coercive social institutions under which they do not have secure access to the object of their human rights.'[204]

[202] Pogge, 2010, p.29

[203] He writes: 'This institutional understanding narrows the philosophical gap because it does not sustain the thought that civil and political human rights require only restrain, while social and economic human rights also demand positive efforts and costs. Rather, it emphasizes negative duties across the board.' (Pogge, 2008, p.70)

[204] Ibid, p.66

Although the duty to reform institutions derives immediately from the duty not to interfere with the secure access to basic human needs, these two duties do not share the exact same features.

First of all, while the duty not to impose or maintain or create avoidable insecure access to basic human needs is negative, its infringement gives rise to a positive duty: the duty to compensate, remediate and reform. Hence, while the duty not to impose or maintain or create avoidable insecure access to basic human needs requires forbearance[205], the infringement of this duty will justify positive actions for compensation, remediation, or reform.

The duty to remediate the GHC is thus positive, as it requires an action: it requires reforms of certain aspects of the global economic order (as I will explain below), for the purposes of rectifying certain market failures inflicting the crisis. The duty to remediate is a positive duty that immediately derives from a negative duty (i.e. the duty not to impose or maintain or create avoidable insecure access to basic human needs).

Pogge explains the positive duty to remediate the insecurity of access through global reforms, as follows:

> [p]romoting institutional reform is doing something (positive). But the duty requiring one to do so may nonetheless be negative for those who would otherwise, through their involvement in upholding the relevant institutional order, be harming its victims. This is analogous to how libertarians' favorite negative

[205] On the 'universal obligations of forbearance', see: O'Neill, 2000, p.135.

> duty may entail positive obligations: one must do what one has promised or contracted to do pursuant to one's negative duty not to promise/contract without performing. In both cases, the negative duty gives rise to positive obligations only through prior voluntary conduct: one's promise, or one's involvement in upholding a coercive institutional order.[206]

Even those who insist in the 'asymmetry' between positive and negative duties, and are generally skeptical about the former, such as O'Neill, would agree with the (positive) duty to reform the global economic order when it causes injustices and rights-violations. In arguing for a more just global economic order, O'Neill emphasizes the need for 'just reforms' in the following way: 'reforms which build a more just transnational economic order might have to regulate and police international markets, transactions and relations […] so as to prevent both state and non-state powers from oppressing, exploiting or dominating the relatively weak.'[207]

What is more, even libertarians like Nozick would agree on this (positive) duty to remediate a global injustice linked to a violation of a right. In this same vein, Nozick's 'principle of rectification of injustices' comes into play only when a principle of justice is violated[208]; and this mirrors the logic that Pogge adopts for explaining the two inter-linked duties arising from the negative responsibility to respect the right to health.

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[206] Pogge, 2008, p.178

[207] O'Neill, 2000, p.141-2

[208] For Nozick's 'principle of rectification of injustices', see: Nozick, *Anarchy, State and Utopia*, 1974, p.152. I discuss Nozick's theory of justice in chapter 4.

Second, while the duty not to impose or maintain or create avoidable insecure access to basic human needs is general, the duty to compensate, remediate and reform is specific. This means that while the duty not to impose or maintain or create avoidable insecure access to basic human needs applies to all, the duty to compensate, remediate and reform applies only to those who have breached the primary duty not to impose or maintain or create avoidable insecure access to basic human needs.

The positive and specific features of the duty to compensate, remediate, and reform do not, nevertheless, contradict or deny the negative and general aspects of its originator, namely the duty not to impose or maintain or create avoidable insecure access to basic human needs, because only if the latter is infringed, such infringement gives rise to duties of a different feature (positive and specific). Moreover, being 'duties of justice'[209], both the duty not to impose or maintain or create avoidable insecure access to basic human needs and the duty to compensate, remediate and reform can justify the creation of legal institutions that will specify them, and both of these duties can also justify the use of coercion to enforce their compliance on all duty bearers.

In brief, policy makers and philosophers, libertarians and all types of liberals alike would accept the positive and specific features (as explained here) of the duty to reform, because it is dependent, and arises only if the primary negative duty not to impose or maintain or create avoidable insecure access to basic human needs is infringed.

To be sure, the common ground is primarily negative: it encompasses a negative responsibility to respect, which yields two sub-categories of duties: (i) a duty not to

[209] For the definition of 'duty of justice', see O'Neill, 1989, p.224. I will come back to this definition, and further discuss the meaning of 'duties of justice' and its enforceability through the law in chapter 5.

impose, maintain or create avoidable insecure access to basic health needs; and (ii) a duty to compensate or remediate violations of the previous duty. I will now discuss this common ground and its facts, as explained by Pogge, and then discuss its implications in the context of the current GHC.

2.4. What Does the Negative Responsibility for the Human Right to Health Entail in the Context of the GHC?

2.4.1. Applying Pogge's institutional account to the human right to health

Adopting Pogge's institutional account of human rights, we would thus conceive the human right to health as follows:

(i) As a human right, the right to health is universal: all human beings are equal *subjects* of the right to health – i.e. equal right-holders and duty-bearers for the basic health needs of others[210];

(ii) As a type of basic human need, the basic health needs are the precise object of the right to health. Basic health needs, as well as all other basic human needs, have an equal moral value, as they are all objects of human rights[211];

(iii) A violation to the right to health occurs when there is an avoidable insecurity of access to the object of the right to health - i.e. an avoidable insecurity to basic

[210] As argued in chapter 1, basic health needs are the universal and indispensible conditions of a minimally decent human existence. Without these minimum conditions any human existence would be impossible. The moral distinctiveness of basic health needs (as opposed to non-basic health needs) is their moral urgency that justifies more stringent duties, with a stronger normative force. There are more stringent moral duties referred to basic health needs than to non-basic health needs, and therefore human rights law is referred primarily to basic health needs.

[211] As discussed in chapter 1, basic health needs, as opposed to non-basic health needs, are universal and indispensible for any minimally decent human existence.

health needs. And that violation or avoidable insecurity needs remediation. This is particularly the case of the GHC. The GHC, as discussed in the introduction of this thesis, has 2 elements: (i) lack of access to medical knowledge; and (ii) lack of access to medicines. Both medical knowledge and medicines are required to satisfy basic health needs, because they are vital to guarantee a 'minimally decent human existence', as conceptualized in chapter 1. In the circumstances of the GHC, there is an insecure, or a lack of, access to these two particular basic health needs. Pogge argues that this insecurity is avoidable, and thus needs remediation. As I have discussed in the introduction of this thesis, this insecure or lack of access is 'avoidable', according to Pogge, in two ways: firstly, it is avoidable because presumably certain 'comparatively minor modifications' in the global regime of intellectual property rights and international trade regulations would suffice to solve the crisis, requiring, as he argues, 'only slight reductions in the income of the affluent'[212]; and secondly, it is avoidable because powerful and wealthy global players, who currently benefit from the status quo, have been blocking these modifications or reforms of the international system; in other words, but for their convenience and self-interest, the crisis could be adequately addressed with slight rectifications.[213]

[212] For Pogge these modifications and reforms of the global order are 'comparatively minor' because they 'would entail only slight reductions in the income of the affluent'. (Pogge, 2010, p.31). He also argues that: 'It is undeniable that our governments, by pressing this WTO Agreement on the rest of the world, have foreseeably taken out millions of poor persons who would otherwise have survived. Most of these deaths would have been avoided, had our governments not, for the sake of minor material gains for some of us, insisted on the protectionism exemptions, extraction of monopoly rents for our "intellectual property" in seeds and drugs, and other onerous commitments by the poor' (Pogge, 2008, p.22)

[213] As Pogge argues: 'Such reforms have been blocked by the governments of the affluent countries which, advancing their own interests and those of their corporations and citizens, are designing and imposing a global institutional order that, continually and foreseeably, produces vas excesses of severe deprivation and premature poverty-related deaths'. (Pogge, 2010, p.31).

'The components of this global economic order emerge through highly complex intergovernmental negotiations in which the governments and negotiator of the developed countries enjoy a crushing advantage in bargaining power and expertise. Agreements resulting from such negotiations therefore reflect

Having conceived the right to health under Pogge's institutional account of human rights, I should now clarify the duties correlated to such right to health, particularly in the event of a right-to-health violation. The right to health is universal: all human beings are equal *subjects* of this right, meaning that we are all equal right-holders and also equal duty-bearers for the basic health needs of others.

The negative responsibility to respect the right to heath of others is therefore, a universal responsibility. This means that we all share a negative responsibility to respect the object of the human right to health, namely people's basic health needs. The common ground understanding on the negative responsibility to respect the right to heath of others is that it is conceptualized, first, as a 'universal duty'[214]: it is owed by all to all, as a means for guaranteeing equal freedom. Second, it is a 'duty of justice'[215], and therefore, it can be enforced through the law,[216] to the extent that it guarantees equal freedom. And third, it is a 'perfect duty'[217]: it correlates to the claim-right not to have one's secure access to its basic health needs infringed. In essence, the negative responsibility to respect the right to heath of others can be defined as a 'universal duty of justice'[218]: it

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the interests of these rich countries' governments, corporations, and populations – regardless of whether the relevant representatives of the developing countries are corrupt or selflessly devoted to poverty eradication.' (Pogge 2008, p.122)

[214] For the definition of 'universal duties' see O'Neill, 1989, p.189.

[215] For the definition of 'duty of justice', see O'Neill, 1989, p.224.

[216] I will come back to these definitions, and further discuss the meaning of 'duties of justice' and its enforceability through the law in chapter 5.

[217] For the definition of 'perfect duties' see O'Neill, 1989, p.191.

[218] For the definition of 'universal duties of justice' as 'universal principles of obligations', see O'Neill, 2000, pp.137-9.

grounds certain legal institutions, which are justified precisely as a way of recognizing and enforcing this duty in some particular sphere'.

The negative responsibility to respect the right to heath of others is two-fold, as it yields two sub-categories of duties.

The first sub-category: duty to avoid depriving others of their basic health needs

The duty to avoid depriving others of their basic health needs constitutes the negative responsibility to respect the right to health: one is part of the other. The common ground understanding of the duty to avoid depriving is therefore that it is also a 'universal duty'[219], a 'duty of justice'[220] that can be specified and enforced through legal institutions, and a 'perfect duty'[221] that correlates to the claim-right not to be deprived of one's basic health needs.

Also, the content of the duty to avoid depriving others of their basic health needs is as basic and general as its originator. Its content is basic, because it contains only the most fundamental principles for structuring institutions and guiding actions, minimally necessary for guaranteeing equal freedom and respect among human beings[222]. Also,

[219] For the definition of 'universal duties' see O'Neill, 1989, p.189.

[220] For the definition of 'duty of justice', see O'Neill, 1989, p.224.

[221] For the definition of 'perfect duties' see O'Neill, 1989, p.191.

[222] Because it contains only the most fundamental principles, is agreeable and cannot be reasonably denied. O'Neill, following Rawls, explains that a universal principle is a principle on which everybody agrees; Scanlon, on the other hand, gives a slightly different definition: a universal principle is one that cannot be reasonably rejected. In any case, the quality of being universal highlights the importance of the consensus or the common ground for practical reasons. (See O'Neill, 1989, p.189-191; Scanlon, 'Value, Desire and Quality of Life', in *The Difficulty of Tolerance*, 2003, pp.169-186, p.182.)

the content of the duty to avoid depriving others of their basic health needs is general, requiring from all agents, generally speaking, the duty to avoid interfering with the secure access to the basic health needs of others.

In the precise context of the GHC, the common ground understanding is that the duty to avoid depriving others of their basic health needs requires that all global players (i.e. duty-bearers) avoid imposing, maintaining or creating institutions that generate an avoidable insecurity of access to basic health needs. This is the consensus for the sake of a legal order that secures equal freedom and respect, and the relevant legal institutions enforcing this duty will later specify further requirements[223].

The second sub-category: the duty to remediate the deprivation of basic health needs in the context the GHC

It is a common ground understanding that the duty to avoid depriving (first sub-category) and the duty to remediate the deprivation (second sub-category) are interlinked, since the latter only comes into play if the former is not satisfied. This means that the duty to avoid the deprivation is the primary duty, and the duty to remediate the deprivation is the secondary one – and by secondary I mean that the duty to remediate is subordinated to the former duty to avoid deprivation. In other words, the duty to remediate the deprivation is not independent: it only exists for the sake of the former.

When we apply these common ground understandings to the context of the GHC, what do we obtain? In other words, what is the duty to remediate the GHC? In order to answer

[223] I will discuss some possible ways of specifying, allocating, and enforcing the duty to avoid depriving others of their basic health needs at the global level, in chapter 5.

this question we need to analyze how Pogge's institutional account of human rights violation apply to the global institutional order, particularly in the context of the GHC.

2.4.2. Applying Pogge's institutional account to the global institutional order and the GHC

Under Pogge's institutional account of human rights, as discussed above, the universal right to health grounds universal responsibilities for the basic health needs of all human beings with whom we share a social institutional system:

> Responsibility for a person's human rights falls on all and only those who participate with this person in the same social system. It is their responsibility, collectively, to structure this system, so that all its participants have secure access to the objects of their human rights.[224]

Sharing with the victim of a human right violation 'in the same social system' is therefore, a condition for human rights responsibilities. If this is so, do the responsibilities for the GHC meet this criterion? The GHC is engendered by a global market failure (i.e. a failure of the current TRIPs regime), and is maintained and exacerbated by the transactions among global players within the global economic order. Pogge explains the present global economic order as follows:

> In the modern world, the traffic of international and intra-national economic transactions is profoundly shaped by an elaborated system of treaties and

[224] Pogge, 2008, p.66

> conventions about trade, investments, loans, patents, copy-rights, trademarks, double taxation, labor standards, environmental protection, use of seabed resources, and much else […] Moreover, there are significant international interdependencies and cross-border externalities some of which clearly aggravate the situation of the global poor.[225]

The global economic order is therefore, a shared social system: it is a collection of global institutions, comprising global rules and global players, in dynamic interactions with one another. Pogge also adds that the present global economic order is also a 'new' global economic order, since this 'integrated global market economy' did not exist, to this extent of integration, before the end of the Cold War and start of economic globalization[226].

The adjective 'new' to the global economic order is not trivial: it is key to a full understanding of what constitutes a human rights violation. By definition, a violation of a right entails harming or wronging someone by making him worse-off than before. The idea thus implies a temporal comparison between the status quo and the status quo ante. Accordingly, by arguing that the present global order violates the human rights of the global poor, by imposing institutional barriers to their secure access to basic human needs, Pogge is therefore comparing the poor's status quo and their status quo ante – i.e. before the end of Cold War and the intense raise of an integrated global market economy.

In short, one violates someone's human right to health, when one unreasonably makes another person worse-off, by interfering with her basic health needs through a

[225] Ibid
[226] Ibid, p.19

wrongdoing[227]. But how can the TRIPs regime violate the right to health of the poor? To put it in another way: how can the TRIPs regime unreasonably make the poor worse-off? This thesis focuses on one particular failure within the present or new global economic order: a failure within the TRIPs regime that engenders the GHC. I am arguing that this specific market failure causes an avoidable insecurity of access to basic health needs upon the global poor. In other words, I am arguing that a present failure within the TRIPs regime causes a violation of the global poor's right to health. In order to fully argue for this violation, I should therefore compare the status quo (i.e. the existing TRIPs regime) and the status quo ante (i.e. the pre-TRIPs regime), and analyze whether the global poor has been worse-off, and if so, how.

The TRIPs agreement was negotiated in 1994, and this is the precise division between the status quo ante (before 1994), and the status quo (from 1994 onwards). Before 1994, intellectual property was regulated in a very different way in comparison to the present. Until the 1970s, for example, many countries (including developed countries) did not issue pharmaceutical patents. Between the 1970's and the 1990's, pharmaceutical patents started to be issued, but each country had a different regulatory system, with differentiated treatments and degrees of patent protection varying in accordance to the product, its industrial sector, and the circumstances. Until 1994, developing countries such as India, Brazil and Thailand were allowed to locally produce generic versions of formulations that had been patented in other countries. These three

[227] Note that responsibility does not arise whenever one makes someone worse-off, but only when one makes someone worse-off by harming or wronging a person's right. For instance, if I open a shoe shop right next to your shoe shop, and I attract all your clients because I have worked harder to make my shop prettier, if I have studied more carefully the consumer's preferences and tastes so that I could come up with a more strategic business project, if I have spread my advertisement to a larger public, and so on, I have not wronged or harmed you, even though I have made you worse-off by taking all your clients from you, and making your shoe shop close down. This is a legitimate worse-off, resulting from a fair market competition: there was no violation of any right, and therefore there is no duty to redress for your 'pure economic loss' (on the idea of 'pure economic loss' in the Law of Torts, see: McBride, and Bagshaw, *Tort Law,* 2012, p.101).

countries in particular, under the status quo ante, had a very prolific production of generic drugs, which were less expensive, and therefore more accessible than the patented original version. These cheap generic drugs would not only benefit the local population, but also the poor populations outside these countries. Before 1994, therefore, India, Brazil and Thailand, were generic producer countries, which also exported their cheap generic medicines to other countries, especially other developing and least developed countries, whose poor populations would not otherwise have access to those medical treatments.

In 1994, with the advent of the TRIPs regime, the WTO created a united system of intellectual property protection for the whole world. The rule would be the same for every country: the innovator has the right to a minimum of 20 years of monopoly over its innovation[228], and only by the end of the patent term, generic producers would be allowed to copy or re-engineer the original formula. This was a drastic change for many countries: before 1994, many countries, like Brazil for example, did not grant patents on pharmaceuticals. Other countries granted much shorter patent terms. India, for instance, used to issue pharmaceutical patents for a maximum period of 7 years. An additional 13 years of prolonged monopoly therefore, had huge impacts over the Indian generic producers (and all the more over the Brazilian generic industry). The same phenomenon happened in Thailand, the other big generic producer country, whose generic industries suffered big losses. Furthermore, the TRIPs has negatively affected not only the local industries and thus the local development; it has also seriously affected the poor populations of other developing and least developed countries with no capacity

[228] Art.27 and Art.33 of the TRIPs require the minimum 20-year patent term for both product and processes in all fields of technology.

production, and which used to import generic drugs from these generic producing countries.

In this sense, it is argued that, before 1994, the poor had easier and better access to cheap generic drugs than under the current regime[229]. Granting market exclusivity through patents raises prices because of lack of competition; and the higher the prices, the worse the accessibility to the product. The case of pharmaceuticals is particularly problematic because medicines are essential to satisfy basic health needs. It is under these circumstances that it is argued that the TRIPs regime violates the right to health: it requires all WTO-member states to introduce pharmaceutical patents in order to comply with new the international obligations contained in the TRIPs agreement, and such compliance, as argued, has negative effects over the right to health of the poor. It is true that the TRIPs allows differentiated transition periods for the implementation of the minimum standards of intellectual property protection: developing countries were obliged to implement the TRIPs, setting up their national patent legislation and regulatory institutions that complied with those minimum standards by the end of 2000[230]; and the least developed countries will have at least until the end of 2016, with the possibility of an extension[231]. Nevertheless, it is also true that most of the developing countries have met all the requirements before the 2000 deadline, due to the political pressure of wealthy countries, pharmaceutical corporations, and other relevant stakeholders[232].

[229] See: Pogge, 2008, p.21; Hollis and Pogge, 2008, p.53; and Musungu and Oh, 'The use of flexibilities in TRIPS by Developing Countries? Can they promote access to medicines?', in *Study 4C,* CIPIH*,* 2005, p.25.

[230] Art.65.2, TRIPs.

[231] Art.66.1, TRIPs.

[232] Musungu, Oh, 2005, p.25

These facts illustrate the sense in which one is justified in saying that the current global economic order (in its particular aspect discussed here – i.e. the TRIPS regime) is responsible for at least some important degree of the GHC. At first, it might sound paradoxical that a global order can be somehow responsible for someone's diseases, because this suggests some kind of causality. What I precisely mean by the global economic order being responsible for the GHC is this: the current patent rules over medical innovation *exacerbate* or *aggravate* the neglected status of certain diseases for large parts of the world population. How? The current TRIPs regime either makes effective medicines unaffordable, and thus inaccessible to most patients in poor countries, until the end of the patent term (this is what I am calling, in this thesis, the access to medicine problem); or gives no adequate market incentive for medical innovators (such as pharmaceutical companies) to invest their costly research and development efforts on diseases afflicting only or mainly the poor, with little or no purchase power (this is what I am calling, in this thesis, the access to medical knowledge problem). In doing this, the TRIPs regime made the situation of the global poor considerably worse than it was before that regime, and than it could be nowadays with a different regime (see chapter 5).

If we accept that we share a global economic order, and that a specific failure in this global economic order (i.e. a failure within the TRIPs regime) is responsible for at least an important degree of the GHC and its intrinsic right-to-health violations, what are, then, the responsibilities we all share for this global catastrophe?

I have shown in section 2.2, that it is undisputed among policy makers that we share, at least, a universal responsibility to respect the right to health ('universal' meaning applicable to all global players, state and non-state actors alike). In the particular context

of the GHC, I argued that this universal responsibility to respect the right to health gives rise to two sub-categories of duties: (i) first, all global players (state and non-state actors alike, including individual persons, as well as legal persons such as pharmaceutical corporations), have an *obligation to avoid infringing the human right to health of others*; and (ii) second, all global players also have an *obligation to redress adverse human rights impacts with which they are involved, when those impacts are the product of a breach to the responsibility to respect*.

Then, in section 2.3, after discussing Pogge's institutional theory of human rights, I have conceptualized the human right to health in terms of a negative duty, namely the negative duty not to disrupt people's secure access to basic health needs of others. Still building on Pogge's ideas, we can further explain this negative duty not to violate the right to health as follows: from this negative duty emerges two successive duties: (i) a duty not to impose, maintain or create avoidable insecure access to basic health needs; and (ii) a duty to compensate or remediate violations of the previous duty. Building on this common ground, I apply, following Pogge, the negative responsibility to respect the right to health of others, to actions that can affect institutions (as, for example, setting up a new treatise that establishes new legal rights and duties). This yields a further specification of the two duties that compose the responsibility to respect the right to health: (a) a duty to avoid infringing the human right to health of others, by avoiding imposing, maintaining or creating institutions that generate an avoidable insecurity of access to basic health needs; and (b) a duty to remediate violations of the previous duty.

2.4.3. Applying our definition of the negative responsibility to respect the right to health to the context of the GHC

How does our definition of the responsibility to respect and its two sub-categories apply to the institutional understanding of the right to health and its negative duty not to violate the right to health? Given the facts mentioned above, I argue that the TRIPs regime was a violation of (a), and that it should therefore, be compensated according to (b).

As discussed above, policy makers and philosophers say that the global economic order and the TRIPS regime, in particular, worsen the situation of the developing countries and of the world poor in particular. To this extent, these global institutions deprive them of both access to medical knowledge and access to medicines, which they had before the TRIPs regime, as explained above. By depriving them of medical knowledge and medicines which they had under the previous regime, the global economic institutions are depriving the poor of their basic health needs, since both medical knowledge and medicine are vital to satisfy one's basic health needs.

What are the conducts or policies that global economic institutions adopt that engender such deprivation, and what are therefore, the conducts or policies that global economic institutions have the duty avoid?

Certain global economic policies interfere with the poor's secure access to their basic health needs, by imposing, maintaining and creating certain institutions that disrupts their secure access to medical knowledge crucial for the research and development of new essential medicines or cheap generic versions of essential medicine that have already been developed. For example, as previously discussed, by imposing the same level of intellectual property protection to all scientific discoveries (independently of the

nature of the product, or its purposes)[233], and upon all jurisdictions (i.e. all WTO member-states)[234], the TRIPs Agreement forbids the sharing and diffusion of medical discoveries before the end of the patent term. This delays people's access to the protected/patented medical knowledge for a minimum of 20 years, and, as a consequence, no further development through re-engineering or adaptation of the formula in a way that is more adequate to the specific diseases and needs of the poor is possible. On top of depriving access to protected medical knowledge for decades, the TRIPs regime also deprives the poor of having access to the cheap generic formulas they had before 1994. The TRIPs Agreement forbids generic production before the end of the patent term, therefore impeding competition among drug producers, and allowing the maintenance of monopoly prices. And also, even after the expiry of the patent term, when generic producers are allowed to sell cheap generic versions in their jurisdiction, the TRIPs forbids them to sell in other jurisdictions, including poor countries in greater need of that generic drug, since the TRIPs forbids parallel imports (a prohibition that did not exist before). Thereby, the duty to avoid depriving the poor of their basic health needs is breached.

The infringement of the primary duty not to deprive people of their basic health needs by interfering with their secure access to medical knowledge and medicine, gives rise to a secondary duty to redress the foreseeable adverse impacts of such interference. The duty to redress the adverse impacts is a specific duty, in terms of both its object and its

[233] There is no discrimination between, for example, a new software for smart-phones and medical treatments. Also, there is no discrimination between a medical treatment for acne or a medical treatment for tuberculosis.

[234] As explained above, the TRIPs allowed differentiated transition periods for developing and least-developing countries. Nevertheless, once the transition period is finished, all jurisdictions have the obligation to comply in full with the TRIPs standards, if they do not want to be penalised by the WTO economic sanctions.

subject. The object of the remediation is limited to the foreseeable adverse impacts on access to medical knowledge and access to medicine that the TRIPs regime engenders. The subject of the duty to remediate is defined: it falls specifically on those who are involved in the interference, by either causing, contributing to, or benefiting from these adverse impacts. These different ways in which one can be involved in the interference will justify different degrees of responsibilities. In chapter 3, I will discuss the different degrees of involvement and responsibilities. For now it suffices to say that all global players have some degree of responsibility, as they all at least help uphold the global economic order (i.e. the TRIPs regime) as it is. Some global players will bear more responsibility than others. For example, one may argue that a wealthy state may have greater responsibilities because they not merely help uphold the system, but they actually impose and directly influence the final shape of TRIPs regulations. The same may be said, for example, of wealthy pharmaceutical transnational corporations with high lobbying powers, who profit millions with the monopoly over their patented products. And another degree of responsibility may arguably apply to an individual medical researcher, citizen of a wealthy country: although he may directly benefit from the existing TRIPs protection, he does not direct shape these rules; in other words, he may benefit substantially, but he contributes very little to the current state of affairs.

In short, different players will relate differently to the breach of the primary duty, namely the duty not to deprive others of their basic health needs, and therefore they will have different degrees of responsibilities regarding the secondary duty, namely the duty to remediate the GHC. Nevertheless, it suffices to say that in the context of the GHC, the duty to remediate it will fall particularly on those global players whose policies and conducts directly disrupt the poor's secure access to their basic health needs. The duty to remediate focuses on the harm caused by worsening the GHC: its object is the

remediation of the additional insecurity of access to basic health needs that has been caused through institutions such as the TRIPs. This remediation involves reforms of the global institutions directly related to the GHC, such as the TRIPs. But these institutional reforms are limited to those aspects of the TRIPs that amount to the GHC (such as the rule on generics, parallel imports and other examples mentioned above). This limitation is justified because the reform aims to precisely correct these market failures causing the crisis within the system. The reform should aim at eliminating the additional obstacles that these institutions posed to the satisfaction of basic health needs after TRIPs. However, this reform does not need to aim at abolishing the TRIPs regime as a whole. I will discuss different reform proposals and institutional solutions to the GHC in chapter 5, and I will argue that the most feasible and thus promising reform proposals are those that precisely tackle the root causes of the crisis (access to medicine and access to medical knowledge), without overlooking or completely denying the logic of the existing order.

Conclusion

In this chapter, I have provided an account of the debate on the responsibilities for the basic health needs arising from the right to health, both within the UN and among philosophers. I have shown that there is some common ground among policy makers and theorists on at least one type of responsibility: the negative responsibility to respect the right to health of others, meaning a negative responsibility to respect people's basic health needs, as the object of the right to health. Based on Pogge's institutional theory of human rights, I have further specified the responsibility to respect, conceiving it as a responsibility, not to infringe people's security of access to their basic health needs. Building on Pogge's theory, I have also discussed the market failures within the TRIPs

regime, which disrupt such security, and thereby inflict right-to-health violations, and exacerbate the GHC.

The responsibility to respect, which constitutes the common ground among policy makers and theorists, justifies certain reforms at the global level on certain aspects of the TRIPs rules and negotiations. This common ground will frame and delimitate the discussions in the next chapters: chapters 3 and 4 will explore the agents that are responsible for imposing, maintaining or creating institutions that generate an avoidable insecurity of access to basic health needs, and to which extent they are responsible, and chapter 5 will explore how the duty to reform these institutions should be most adequately allocated, specified and enforced.

Part B: Defining the Responsible Agents: Who are the duty-bearers of the Right to Health?

Part B, which is comprised of chapters 3 and 4, addresses the question of the agent or groups of agents that bear responsibilities with regard to the right to health (as outlined in part A). In particular, these chapters specify the agents that bear responsibilities of justice to remediate the GHC, as discussed in Chapter 2, recognizing that different agents have different responsibilities in relation to the right to health of the global poor. Part B focuses on the responsibilities of three main agents: (i) states[235], (ii) natural persons, and (iii) pharmaceutical corporations[236]. Chapter 3 will focus on states and natural persons, whilst Chapter 4 will focus on pharmaceutical corporations. I will analyze whether these three different spheres of responsibilities may or may not overlap in some respects.

In chapters 3 and 4, I argue that the responsibility for the right to health (and more precisely the duty to remediate the GHC, as defined in chapter 2) devolves onto state and non-state agents (including natural persons, and pharmaceutical corporations); and I will justify their respective responsibilities of justice by explaining how each of these agents are connected to the object of my discussion, namely injustices that are related to the right to health of the global poor in the context of the GHC.

[235] Under this first category, we could also plausibly include international organizations, which are political institutions composed chiefly of states.

[236] Pharmaceutical corporations are legal persons. They are a collective agent, such as the state. While the state is a collective political institution (as a collective of persons sharing a political purpose), pharmaceutical corporations are a collective economic institution (as a collective of persons sharing an economic purpose). As a global player, pharmaceutical corporations, are somehow in between two other global players, namely the states and the natural individual persons, sharing certain features with both. For a detailed discussion on the concept of business corporations, see: Muchlinski, *Multinational Enterprises and the Law,* 1999; Rigaux, 'Transnational Corporations', in Bedjaoui (ed), *International Law: Achievements and Prospects*, 1991; Clapham, *Human Rights Obligations of Non-State Actors*, 2006, pp.76-80, pp.199-201.

The responsibilities of state-agents in relation to the right to health of the global poor are not notably contentious. The declarations within the international law of human rights are unanimous in claiming that states bear 'the primary responsibility'[237] for the right to health of their citizens: as the subject of international law *par excellence*, therefore, states are the main duty-bearers for securing the health needs of their own citizens. Here, I will focus on the scope of states' responsibility for the right to health of non-citizens and individuals outside their jurisdiction, since the primary focus of this thesis is indentifying the responsibilities of wealthy states in relation to the global poor (who are generally not citizens of those states).

As discussed in chapter 2, however, the responsibilities of non-state agents in relation to the right to health of the global poor are very contentious. Chapter 3 will discuss the responsibilities of natural persons (particularly citizens of wealthy nations) in relation to the right to health of other natural persons who are distant, stranger, and poor. These debates will focus mainly on the limits of duties of justice, as opposed to individual reasons for benevolence[238]. Deploying these crucial differentiations, chapter 3 will introduce the discussion on the right-to-health-related responsibilities of persons. Then, in chapter 4, I will focus on the responsibilities of one particular category of legal person: pharmaceutical companies. Chapter 4, therefore, focuses on the specific responsibilities that pharmaceutical corporations have in relation to the right to health of the global poor, based not only on pharmaceutical corporations' direct or indirect interactions with the global poor through their global economic transactions, but also on their unique capacity

[237] See chapter 2.

[238] For the distinction between duties of justice, and reasons for benevolence, see chapter 5.

for remedying the GHC. This debate in chapter 4 is structured around a discussion of pharmaceutical firm's intellectual property rights -- particularly patents.

Chapter 3 – States and natural persons as agents of justice

In this chapter I will question the conventional, state-centric, approach to public international law[239], by arguing that it is insufficient to address the complexities of the current GHC. Instead, I argue in favor of adopting the cosmopolitan approach to public international law. Both the conventional approach and the cosmopolitan approach to public international law provide a framework within which to discuss the human rights responsibilities owed to the global poor, to whom all of us -- as individuals as well as collectives -- share certain communal ties. Each approach nevertheless provides a different understanding of the scope of these responsibilities, insofar as each focuses on different levels of our shared communal ties. Whilst what I call 'the conventional approach' focuses on our political ties based on our membership of a particular nation-state (i.e. citizenship), what I am calling 'the cosmopolitan approach' will emphasize our membership of the global community, either as individual persons or as collective agents (organized as state or non-state actors alike), which interact with one another, and therefore share certain responsibilities for the global common good.

[239] As a legal system, international law is a body of common rules with global application. By public international law I mean the body of law, including both 'hard-law' and 'soft-law' legal documents as well as legal scholarship, which regulates the inter-relations among various global players -- state and non-state actors alike (For a list of some global players relevant to this thesis, see the introduction to Part C). Public international law has traditionally been conceived as regulating three main types of inter-relations: (i) between nation-states; (ii) between a nation-state and its own citizens and other actors within its jurisdiction; and (iii) between a nation-state and actors outside its jurisdiction. What I am calling 'the conventional approach to public international law' is a state-centric view that argues that only state actors are full subjects of public international law, where 'subjects' mean both right-holders and duty-bearers (see footnote 8 below on the conventional approach). What I am calling 'the cosmopolitan approach to international law' includes states and non-state actors -- such as transnational corporations, international NGOs, paramilitary groups, and also individual persons (see footnote 11 below) – as subjects of international law, and thus as right-holders and duty-bearers. The cosmopolitan approach to public international law, therefore, would regulate a wider range of inter-relations among global players: (i) between nation-states; (ii) between a nation-state and its own citizens and other actors within its jurisdiction; (iii) between a nation-state and actors outside its jurisdiction; (iv) between non-state actors across jurisdictions.

Each of the two approaches has important normative consequences, which particularly resolve two issues: firstly, whether states should grant priority to the moral claims of their citizens (whether they appear in the form of basic needs, rights, etc.); second, whether states are the exclusive subjects of international law (and therefore they alone bear human rights and global justice responsibilities), or whether other non-state actors are also subjects of international law (and thus also possess these responsibilities in some degree). I will argue that the cosmopolitan approach offers a more complete and accurate model, because it does not overlook the crucial role currently played by non-state global players[240]. Consequently, the cosmopolitan approach is more adequately suited to an analysis of the question of which agents have responsibilities to remediate a global problem such as the GHC[241].

The discussion of the responsibilities that states bear for the human right to health is central to the public international law declarations and associated scholarship. The conventional account is markedly state-centered: it focuses on the concept of the nation-state and its related ideas of nationality/citizenship, sovereignty, national boundaries, geographical proximity, and cultural identity. The conventional account of public international law posits that states are the exclusive subjects of international law[242], and

[240] I am using the words players, actors, agents and subjects interchangeably (see introduction to Part C).

[241] On the duty to remediate the GHC, see chapter 2.

[242] In 1920, Oppenheim introduced the idea of subjects of international law as follows: 'the conception of International Persons is derived from the conception of the Law of Nations. As this law is the body of rules which the civilized States considers legally binding in their intercourse, every State which belongs to the civilized States, and is, therefore, a member of the Family of Nations, is an International Person. And since now the Family of Nations has become an organized community under the name of the League of Nations with distinctive international rights and duties of its own, the League of Nations is an International Person *sui generis* besides the several States. But apart from the League of Nations, sovereign States exclusively are International Persons – i.e. subjects of International Law' (Oppenheim, *International Law: A Treatise*, 1920, p.125).

For Browlie, a subject of international law is 'an entity capable of possessing international rights and duties and having capacity to maintain its rights by bringing international claims. Browlie talks about the subjects of

as such each state bears human rights responsibilities towards its own citizens, as well as certain humanitarian aid responsibilities for outsiders (i.e. citizens of other nations)[243]. This chapter discusses Miller's theory of justice, which endorses and provides a philosophical explanation for this legal approach that I have termed 'conventional'. Miller's theory is particularly interesting for the purpose of this thesis because he provides the philosophical foundations of the conventional approach to public international law, by discussing the moral duty to remediate global poverty that we, as individuals and collective agents politically organized as nation-states, may or may not owe to certain outsiders, namely the non-citizens comprising the global poor.

The conventional account of public international law has been challenged over the past five decades by a school of thought broadly termed 'Cosmopolitanism'[244], which has especially challenged the conventional claim that the state has a duty to prioritize

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international law as holders of a 'capacity to make claims in respect of breaches of international law; capacity to make treaties and agreements valid on the international plane; and the enjoyment of privileges and immunities from national jurisdictions' (Browlie, *Principles of Public International Law*, 2003, p.57).

[243] See, for example, Crawford, *The International Law Commission's Articles on State Responsibility: Introduction, Text and Commentaries*, 2002; Crawford and Olleson, 'The Nature and Forms of International Responsibility', in Evans, *International Law*, 2003, pp.445-72; Bull, *The Anarchical Society - A Study of Order in World Politics,* 1977; Bull, 'Hans Kelsen and International Law', in Tur and Twining (eds.), *Essays on Kelsen,* 1986; James, 'Law and Order in International Society', in James (ed.), *The Bases of International Order - Essays in Honour of C.A.W. Manning,* 1973; Manning, 'The Legal Framework in a World of Change', in Porter (ed.), *The Aberystwyth Papers - International Politics, 1919-1969*, 1972.

[244] The idea of 'cosmopolitanism' has been discussed both legal theorists, as well as political scientists and philosophers. In this chapter I aim to clarify what the cosmopolitan approach may entail in the field of law. In order to do so, I will engage with the philosophical and foundational debate, focusing especially on the disagreements between Miller and Pogge.

In moral and political philosophy, the debates on cosmopolitanism have been framed around the theme of Global Justice, since Rawls' Law of Peoples. Two main school of thoughts have developed from the initial discussions on the Law of Peoples: (i) the interactionalists, like Singer and Caney, who focus their discussions on the interactions between agents, whose conducts may produce injustices in need of remediation; and (ii) the institutionalists, like Miller, Pogge, Nagel and Beitz, who focus their discussions primarily on the global economic institutional order, and the global economic interdependence and inter-relations between the various institutional players, whose institutional policies may produce injustices in need of remediation. Within the later group, further classifications can be made: for example, Miller is often classified under the sub-category of Statists/Nationalists/Communitarians, who focus their discussions primarily on one particular institutional agent: the nation-state.

citizens over non-citizens. Miller provides a complete explanation of the conventional claim, justifying why citizens should take priority over non-citizens. Nonetheless, scholars who typify what I am here calling 'the cosmopolitan approach to public international law' robustly contest this central principle of the conventional approach: Eleftheriadis and Pogge, for instance, provide compelling reasons to reject the necessary priority of citizens over non-citizens, by highlighting cases where such priority is arbitrarily stipulated.

Pogge provides the most complete, accurate and sophisticated cosmopolitan theory of justice to date. Arguing against the necessary priority of citizens, he develops a theory of global institutions, through which he argues that, nowadays, state-actors are not the exclusive subjects of international law and bearers of human rights responsibilities: non-state actors play a crucial role in the present global economic order and, as such, bear certain human rights and global justice responsibilities. In fact, for Pogge, all global players -- state and non-state actors alike -- bear certain responsibilities for the global poor, because all global players share with the poor the same global economic order, and because global poverty, as he defines it, is an avoidable outcome of the existing global economic order sustained by global player's global economic transactions between each other.

The cosmopolitan approach of public international law claims, then, argues that, in view of the complexities brought to the contemporary situation by globalization, it is now difficult to determine responsibilities of justice solely on the grounds of the conventional ideas of nation-state, nationality/citizenship, sovereignty, national boundaries, geographical proximity, and cultural identity. This is because the conventional approach overlooks the active participation and significant influence of non-state transnational

players in the ongoing construction of the global order. Most importantly, the conventional approach overlooks the high degree of interrelation between a person and another person who is not a member of the same state, and between a state and persons who are not members of that state[245]. Certainly, the cosmopolitan approach of public international law does not question the conventional premise that human rights responsibilities lie first and foremost with states. Nonetheless, the cosmopolitan approach does question the idea that the state has a duty to give priority to its own citizens. In questioning this idea of the necessary priority of citizens over non-citizens, cosmopolitans will put forth their main claim on the shared responsibilities of all global players (state and non-state players alike) for the global poor (mostly citizens of developing and under-developed nations).

The theme of non-state actors and human rights responsibilities, and particularly the theme of transnational corporations and human rights responsibilities, is still very contentious, not only doctrinally, but also politically. As I have discussed in chapter 2, within the UN for instance, the independent experts[246] dealing with this issue do not appear to have come to an agreement on the extent and content of these responsibilities. It is, therefore, the intention of chapter 3 to illuminate some of the relevant moral distinctions concerning the inter-relations between states and non-state players with the global poor (as well as the responsibilities that arise from these relations). Chapter 3 will therefore develop the premises established in chapter 2, where

[245] See for example Clapham, 2006, pp.25-32; Alston, *Non-State Actors and Human Rights*, 2005; De Schutter (ed), *Transnational Corporations and Human Rights*, 2006.

[246] Ruggie, the special representative of the UN secretary-general on business & human rights, argues that corporations have the duty to the respect human rights, while Hunt, the former special rapporteur on the right to health, argues for the full application of the human rights duties to respect, protect and fulfill, onto companies.

the duty to remediate the GHC was established. Here I will discuss the fundamental reasons why all global players (and states and their wealthy citizens in particular) bear certain responsibilities to remediate the GHC.

This chapter is structured as follows. Firstly, I will explain Miller's theory, which supports the conventional school of public international law, arguing for the priority of citizens over non-citizens when it comes to define the sorts of responsibilities that states bear for non-citizens. Miller's support for the priority of citizens is challenged first by Eleftheriadis. Pogge will also argue against the priority of citizens, and in doing so, he will introduce his cosmopolitan theory, according to which all global players – state and non-state actors alike – bear certain human rights and global justice responsibilities for the global poor. This chapter will argue in favor of Pogge's cosmopolitan theory of justice as the most complete, accurate and sophisticated theory to date, and, in doing so, it will accept his argument that international law and human rights responsibilities fall on all global players, state and non-state actors alike.

Pogge's theory engages with Miller's ideas, and offers a canonical understanding of the cosmopolitan view, which highlights the crucial role that states and non-state actors alike (particularly wealthy natural persons, citizens of wealthy nations) play in relation to the existing problem of global poverty. In order to complement Miller's theory, and challenge Miller's argument on the priority of citizens, Pogge proposes six different scenarios, which he uses to explain the different degrees of moral responsibility that different agents bear with regard to one specific problem. Pogge's scenarios will prove to be a helpful moral framework for the debate concerning right to health responsibilities. In order to narrow and specify Pogge's general account, I will, in the last section of this chapter, reformulate Pogge's six scenarios, applying his general framework to the

precise context of the GHC. This allows me to demonstrate how state and non-state global players alike are all institutionally connected to the global poor and ill, and thereby show why state and non-state actors alike bear certain duties of justice (not only benevolence) to remediate the GHC[247].

3.1. Miller and the conventional approach to public international law

Miller's theory of justice is a helpful means of understanding the philosophical basis of the conventional state-centered perspective of international law. According to both Miller and the conventional view, states bear the primary responsibility for respecting, protecting, and fulfilling the human rights of their citizens, whilst also having certain humanitarian aid responsibilities for non-citizens (including the global poor)[248]. For Miller, there are responsibilities that we -- as individual citizens of wealthy countries, as well as collectives politically organized in communities called nation-states -- share in relation to unjust situations of global poverty, but these responsibilities are less stringent than those we share in relation to situations within our own jurisdiction.

For Miller, we, as individuals and collectives, bear a remedial responsibility for unjust global poverty. Unjust global poverty, for Miller, is a specific circumstance of deprivation of basic needs that is unjust because it entails the violation of basic human rights[249].

[247] Chapter 2 discusses and specifies the duty to remediate the GHC.

[248] Miller, 2007[A]

[249] I have discussed Miller's ideas of 'basic needs' and 'a minimally decent human existence', and why their negation constitutes a human right violation on chapter 1. Miller provides a list of basic human needs that justifies basic human rights; his list includes: 'food and water, clothing and shelter, physical security, health care, education, work and leisure, freedoms of movement, conscience and expression'(Ibid, p.184).

Unjust global poverty is a 'morally intolerable' situation, which is urgent and severe enough to trigger our remedial responsibilities in relation to outsiders[250]. For Miller, this remedial responsibility is a 'collective responsibility': since the most significant 'collective' in which we participate is the nation-state, it makes sense to adopt the perspective of nation-states in discussing global justice and poverty[251]. Miller also highlights the reason why questions of responsibility are raised in the context of global poverty: since 'global poverty on the scale that we now witness is a harm in need of remedy', 'questions about responsibility [for outsiders] are unavoidable'[252], and therefore one cannot discuss global poverty and its enormously harmful effects without talking about a certain 'remedial responsibility' that bear towards non-fellow nationals. But what precisely does 'remedial responsibility' mean for Miller?

For Miller, we share a collective responsibility to remediate unjust situations of global poverty[253]. He develops his argument by first mapping out all the plausible reasons why one might bear a remedial responsibility[254]. Miller identifies six key criteria, which 'suggest six ways in which remedial responsibility might be identified'[255]; whilst the first four criteria explain the 'different ways of redressing a wrong or an injustice', the last two (namely 'capacity' and 'community') determine 'who should help people in need'[256].

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[250] Ibid, pp.185, 232

[251] Miller, *Collective Responsibility for Global Poverty*, paper presented to the workshop on Shared Responsibility, University of Oxford, Faculty of Law, 7-8 September, 2012.

[252] Ibid, pp.1-2

[253] Miller, 2007, especially chapters 7 and 8

[254] Ibid, pp.81-109

[255] Ibid, p.100

[256] Ibid, p.106

(i) ‘Moral responsibility’

The agent is responsible for remediating harm because he is morally responsible for the production of this harm: he has acted in a faulty or blameworthy way, either deliberately or recklessly.

(ii) ‘Outcome responsibility’

The emphasis is placed on the identification of the responsible agent, independent of a moral evaluation of their conduct. Outcome responsibility, therefore, is distinguished from moral responsibility: here, an agent may bear remedial responsibility even if their causing the harm was not morally blameworthy (indeed, even if their conducts was legitimate). Here, the agent has the responsibility to remediate harmful outcomes simply in virtue of their causal relation to this harmful outcome. Miller gives the example of an undesired and unfortunate side-effect arising from a fair economic competition: ‘A is better at business than P, or has more luck’, and A’s success causes P’s business to close its door, and go bankrupt. According to Miller, A has a remedial responsibility for P’s unfortunate outcome, simply because A ‘has brought about the [outcome of] deprivation’.

This is a typical example of what is in law called ‘pure economic loss’. Although, legally speaking, A has no legal responsibility to remediate P’s unfortunate loss, no matter how heavy P’s costs are, Miller, who is making a more foundational moral point, insists that

> people who drive others out of business in the course of fair competition, are not expected to provide compensation, nor are athletes who win races expected to comfort the losers. But if the costs are heavy – the defeated shopkeeper

> becomes destitute, or the loosing athlete becomes suicidal – then remedial responsibility cuts in and, all other things being equal, they fall to the agent who was outcome responsible.[257]

Miller recognizes that his point here is contentious; yet he relies on this intuition to provide an example of outcome responsibility. As he himself acknowledges:

> Not everyone shares my intuition that in these competitive examples the winners may have remedial responsibilities to the losers when the latter suffer serious harm. Of course, we can establish practices that assign these responsibilities elsewhere – we can set up social security nets for bankrupt shopkeepers and counseling services for defeated athletes – and there may be good reason to do this. My argument is that in the absence of such practices primary responsibility lies with the agent who is outcome responsible for the harm.[258]

(iii) 'Causal responsibility'

The agent bears remedial responsibility because there is a causal connection between his conduct and the harmful outcome of his conduct, regardless of possible further excuses for such causal connection, such as coercion or constraint (which may nevertheless be taken into consideration in a subsequent stage of actual adjudication). While outcome responsibility focuses on the identification of all responsible agents, capable of remediating the harmful outcome, causal responsibility is distinctive in focusing on the identification of the causal link itself. In law, this is typically called

[257] Ibid, p.101

[258] Ibid.

'causation', where a causal link between the agent's conduct (action or omission) and the harmful outcome constitutes one of the first steps in justifying the liability (i.e. legal responsibility) of that particular agent. However, here Miller is again looking at a more foundational philosophical level of justification, where the burden of legal evidence is not strictly required. On Miller's theory of justice, it suffices to show a general link between conduct and outcome.

He gives the example of a pedestrian, who stumbles, causing a workman standing on a ladder to fall off. For Miller, the pedestrian has the responsibility to aid the workman, by virtue of his causal connection to his falling and physical injury. As he puts it:

> My stumbling in the street might have been unavoidable; there may be others who are equally well placed to pick up the person I have knocked over: nevertheless the bare fact that I have caused him to fall connects me to him in a special way and *ceteris paribus* makes me remedially responsible.[259]

Miller acknowledges the difficult of distinguishing pure causal responsibility from moral responsibility and outcome responsibility. Nevertheless, he treats 'causal responsibility as an independent source of remedial responsibility, one that continues to be relevant even in the absence of the other factors […] in the absence of other forms of connection, the importance of fixing remedial responsibility somewhere explains why bare causation can count'[260].

[259] Ibid, p.102

[260] Ibid

(iv) The idea of 'benefit'

The remedial responsibility of the agent is precisely located neither in their morally defective conduct, nor in their causal role in bringing the harm about, but rather simply because he is benefiting from someone else's deprivation. Miller writes:

> Suppose that A has played no causal role in the process that led to P's deprivation. He has nonetheless benefited from that process – for instance, resources that would otherwise have gone to P have been allotted to A. In these circumstances, A is not responsible for P's condition in any of the three ways we have so far identified, and yet indirectly he is linked to that condition. He is an innocent beneficiary, let us assume, but the benefit would not have arisen unless P had been deprived. This may be sufficient to make him remedially responsible for P.[261]

In law, this normative framework that Miller spells out is called 'unjust enrichment', which justifies a specific legal remedy called 'restitution': one person is unjustly or by chance enriched at the expense of another, and from this profit arises a duty to make a restitution for the benefits unfairly received and retained. Another example in law of this normative framework presented by Miller is the case in which a party benefits from an illicit activity for which he is not responsible. For example, A enters into a contract, after been deceived by the *dolus* of another party B. The contract produces harmful effects to A, and benefits to both B and C (who did not participate in the deceiving). Clearly, B has the duty to compensate A for the harm he endured. And C also has a duty to compensate, which is independent of her motives: C has a duty to compensate A

[261] Ibid, p.102-103

because he has benefited from the contract, and C shall respond up to the limit of the benefits he has received derived from the contract.

(v) The idea of 'capacity'

The agent is remedially responsible simply in virtue of his capability to supply remedy and effectively correct the harm. As Miller explains it: 'where several agents are to different degrees capable, we may assign responsibility to the most capable, or divide it between them along the lines of the classic principle: "From each according to his abilities, to each according to his needs".'[262]

(vi) The idea of 'community'

The agent is remedially responsible for his fellow-members simply in virtue of his shared communal ties. This principle is the conceptual core of Miller's theory of global justice, since in essence he argues for a 'special obligation to fellow-members'. For Miller, this criterion alone can sufficiently justify remedial responsibility, as 'communitarian relationships' are in general independent of, and prior to, the fact of P's deprivation. For Miller, if P is deprived and needs assistance, the first and most obvious place to look for help is among the agents linked to P in some way: family, friendship, collegiality, religion, nationality, etc[263]. Although the criterion of 'community' (meaning the kind of membership informed by the ideas of nationality/citizenship, sovereignty, national boundaries, geographical proximity, and cultural identity) is central to Miller's theory, constituting an independent reason that can justify remedial responsibility, he acknowledges that it can overlap with the criterion of capacity:

[262] Ibid, p.103

[263] Ibid, p.104

> In some cases being connected to P by ties of community will also mean having certain kinds of expertise that will help in relieving her condition: if A and P share the same language or cultural background, for instance, A may be better able to work out what P needs. So here community is connected with capacity. But this is a special case, and it would be a mistake to try to reduce community to one of the forms of connection already discussed. It stands on its own feet as an independent source of remedial responsibility.[264]

So, although community can feature in a capacity argument, community is an independent source of remedial responsibility, simply by featuring the shared communal ties between agents.

In brief, for Miller, each of these six criteria provides an independent and sufficient reason that can justify general remedial responsibilities. In the specific case of global poverty, however, Miller remarks that, although any of the six criteria can independently and sufficiently provide good reason to justify our general responsibility to remediate the deprivation of basic needs and the violation of the world poor's basic human rights, there might be a practical need for further specifications in relation to this general six-fold claim on the remedial responsibilities for the poor. Miller highlights that effective and enforceable remediation of unjust global poverty requires further practical considerations for these remedial duties for the poor, because this is a complex practical problem. One may need to combine the six criteria mentioned above with additional justifications in order to convince those resistant responsible agents who have contributed to unjust

[264] Ibid

global poverty, but who may not be really willing to contribute to remediate it[265]. As he puts it:

> In many, probably most, real-world cases of deprivation, assigning remedial responsibility involves applying multiple criteria, which are also somewhat opaque. It may be uncertain how the deprivation came about, and whether the roles played by individual agents in that process are such that they bear moral or outcome, as well as causal, responsibility. Questions of capacity may be equally problematic. […] If we take a complex case, such as poverty in developing countries, all of these questions arise, and it may seem that fixing remedial responsibility is impossible. Such cases certainly show us why having formal mechanisms for assigning responsibility are so vital – in the absence of such mechanisms, everyone can find a plausible reason for shifting the burden of responsibility elsewhere. In designing the mechanisms, however, we have no alternative but to consider each of the agents – primarily states and international institutions – able to provide a remedy and then to assess how strongly each is connected to the impoverished group.[266]

Institutional mechanisms that can further specify and even enforce the remedial responsibilities are relevant, therefore, especially in complex cases of unjust global poverty that generates human rights violations, where certain legal enforcement may be desirable and needed. Nevertheless, for Miller, one first needs to identify all possible responsible agents (according to any of the six criteria), and, from there, specify other

[265] Miller, 2012, p.3

[266] Miller, 2007, p.107

considerations relevant to the establishment and enforcement of remedial responsibilities for unjust global poverty and human rights violations. As Miller remarks, there may be cases, for instance, where a certain nation-state can be remedially responsible in general terms for a unjust global poverty-related harm, even though that same nation-state cannot be rendered outcome responsible for the same wrong[267]. According to Miller's theory, this would be the case, for example, when a nation-state is benefiting from global poverty by exploiting other peoples; or when an affluent nation-state has full capacity to aid other peoples in need, with effectiveness and without incurring major costs for themselves. Both 'benefit' and 'capacity', according to Miller's theory are strong enough criteria to justify a general remedial responsibility, even if they might not be sufficient to justify a legally enforceable 'outcome responsibility'.

Although Miller acknowledges this difference between stringency and enforcement in his idea of a more general remedial responsibility, and a legally enforceable duty to remediate an injustice, it is *prima facie* unclear, according to Miller's six-fold idea of remedial responsibility, where there limits for our responsibilities lie -- as individuals and as collectives -- for the global poor. If any of the six criteria, which introduce very general reasons, can be sufficiently strong to ground a duty to remediate unjust situations of global poverty, Miller's theory would seem to endorse a very demanding and unreasonable claim, where we are responsible for all the poor individuals of the world in every possible way[268]. On this reading, Miler's six-fold idea would support the view that whenever there is an unjust situation of global poverty, and any or some of the six

[267] Ibid, pp.260-261

[268] Singer, for example, would endorse this perspective and argue in this direction, claiming that we – rich individuals of Western societies – are responsible for all the poor people in the world, in every possible way, as we shall help them as much as possible. See Singer, 'Famine, Affluence, and Morality', in *PAPA*, 1, 1972, p.231.

criteria apply, there would be a remedial responsibility on the part of the person for which the criteria apply.

3.1.1. 'Citizenship' and the limits of our remedial responsibilities for the global poor

In order to define and justify the reasonable limits of our remedial responsibilities for global injustices, Miller draws a distinction between two different spheres of justice: the social and the global. The sphere of social justice relates to the national or domestic context, being the 'justice practiced among people who are citizens of the same political community'[269]. The basic feature of social justice is the primacy of each nation-state as the bearer of responsible for what Miller calls the 'rights of citizenship': an all-encompassing list of civil, political, social, economic, and cultural human rights equally possessed by all fellow-members of that particular community[270]. The idea of 'citizenship' is, therefore, crucial to Miller's theory, as it determines people's different degrees of relationships and thus responsibilities to one another within their political community, in the domestic context of their own nation-state. The idea of 'citizenship' will also be relevant at the global level: in differentiating fellow-nationals and 'outsiders', it clarifies the different degrees of relationships, and thus responsibilities, that a nation-state and its citizens owe to other peoples (i.e. outsiders, including other nation-states and their citizens) as a matter of global justice[271].

[269] Miller, 2007, p.15

[270] Ibid, pp.167, 183.

[271] Ibid, p.17

However, the sphere of global justice, as Miller remarks, is not merely a stretched version or a universalized rehashing of his concept of 'social justice': for Miller, there is no equivalent to 'rights of citizenship' at the global level. Instead, Miller talks about a 'global minimum that people everywhere are entitled to as a matter of justice': a selected list of 'rights to subsistence'[272]. As discussed in chapter 1, these 'rights to subsistence' are based on those basic needs that humans 'everywhere must have in order to live a decent human life'[273]. Miller seems here to build on the Rawlsian idea of a minimalist list of human rights, complemented by Shue's ideas of basic rights of subsistence, as he explains that the violations of these 'basic rights of subsistence' are 'urgent enough to trigger remedial responsibility in outsiders'[274]. So, according to Miller, we all bear, as individual citizens and as collectives politically organized as nation-states, a global minimal responsibility to provide for the basic human rights of poor outsiders (i.e. poor non-fellow nationals in developing or under-developing nations) as a matter of justice. And this is, for Miller, what we all precisely owe to the global poor as matters of justice and rights. In other words, this selected list of 'human right to subsistence' is the exact limit of our remedial responsibilities of justice for non-citizens.[275]

The distinction between rights and duties linked to the domestic context of 'right of citizenship', on the one hand, and rights and duties linked to the global context of human right to subsistence, on the other, is an important one. A similar distinction is made by

[272] Ibid, p.166

[273] Ibid, p.198

[274] Ibid, p.167

[275] For a discussion of Miller's idea of basic human rights (including the basic rights to subsistence), based on his basic needs account, see chapter 1.

Eleftheriadis[276], who distinguishes between the 'obligation of citizenship', owed by citizens to their own states, and by states to their own citizens; and the 'cosmopolitan political obligation', owed by every individual person to every legitimate nation-state, by every legitimate nation-state to every individual person, and also by every individual person to every individual person[277]. It is important to remark that Eleftheriadis takes the standpoint of the duty-bearers instead of the right-holders, as Miller does; and this paradigm shift helps to further explain the remedial responsibilities of potential duty-bearers in relation to the global poor. For Eleftheriadis, we, as individuals or collectives, owe to each other a cosmopolitan political obligation, because we owe to each other a natural and universal duty of respect[278].

Both Miller and Eleftheriadis's theories provide a moral framework for discussing the political obligations of wealthy states and their wealthy citizens in relation to developing and under-developed states and their citizens. Both Miller and Eleftheriadis provide a moral framework based on communal state-centred political ties, thus providing tolls to discuss the conventional state-centric approach to public international law. While Miller focuses on the communal political tie of citizenship/nationality, Eleftheriadis, on the other hand, challenges the sufficiency of this precise tie (i.e. citizenship/nationality), arguing for an alternative communal political tie that is cosmopolitan in its scope.

[276] Eleftheriadis, 'Citizenship and Obligations', in Dickson, and Eleftheriadis, *The Philosophical Foundations of European Union Law*, 2012, pp.159-188; Eleftheriadis, 'Citizenship and Obligations', in *Legal Research Paper* series, Paper N. 45/2011, September, 2011

[277] Eleftheriadis, 2012, p.24

[278] Ibid, pp.24-25

3.1.2. Citizenship as an insufficient justification for the limits of remedial responsibilities for Global Poverty

The contrast between Eleftheriadis and Miller is particularly useful because Eleftheriadis clearly demonstrates the ways in which the category of citizenship is both insufficient and unreasonable. In so-doing, he frames the debate regarding the cosmopolitan account of public international law, which will be fully discussed in section 2. Eleftheriadis does not directly address the question of global poverty in this paper, but his arguments against the sufficiency and reasonableness of citizenship/nationality as a marker for the limits of remedial responsibility contribute to a more complete explanation of the scope of remedial responsibilities towards the global poor (i.e. needy non-citizens). Eleftheriadis is, therefore, a proponent of a cosmopolitan theory of political obligation, which is applicable to both domestic and international institutions. It is in this context that he explains the 'cosmopolitan political obligation': 'a moral duty that applies universally to all. It can be owed by everyone to any state and to any legitimate international body and institution'[279], and 'by all states to all persons, citizens or non-citizens'[280]. As such, the 'cosmopolitan political obligation' explains precisely what all of us -- as individual members of political communities and as collectives/political communities themselves -- owe to all other individual persons and to all other political communities in the world. And, for Eleftheriadis, we owe everyone else -- including the global poor, independently of their citizenship/nationality – a duty of reciprocal respect. The cosmopolitan political obligation is therefore based on a moral duty of reciprocal respect, based on the principles of fairness and international cooperation. Miller also

[279] Ibid

[280] Ibid, p.28

recognizes reciprocal respect not only as a universal natural duty, but also as the key principle of justice at the global level. In Miller's own words: 'what international cooperation requires is indeed not fraternity but mutual respect between political communities who recognize their differences but also realize that they need to work together in a number of policy areas'[281].

Eleftheriadis's theory, therefore, shares with Miller's theory the focus on communal political ties justifying political responsibilities grounded on moral duties of cooperation and reciprocal respect. The difference between them lies on the type of communal membership each of them have elected to justify the scope of the communal political responsibilities each of them propose: while Miller justifies communal political responsibilities based on one specific type of membership – i.e. citizenship; Eleftheriadis justifies communal political responsibilities based on a different type of membership -- i.e. cosmopolitan membership. While Miller's view on citizenship is the form of membership tying each person to their respective nation and each nation to its own citizens, Eleftheriadis' idea of cosmopolitan membership goes beyond the national boundaries to include outsiders: it ties each human being to the global community and the global community to each human being. However, whilst Miller recognizes that certain remedial responsibilities extend to outsiders, he nonetheless insists on the precedence of citizens over outsiders, with whom the nation may share other types of significant communal ties. This difference between Miller and Eleftheriadis is not trivial, as it will delimit communal political responsibilities with markedly different scopes: while the communal political responsibilities based on citizenship will justify the priority of

[281] Miller, 2007, p.79

citizens over and above non-citizens, the communal political responsibilities based on cosmopolitan membership will militate against this necessary priority.

Both Miller and Eleftheriadis, then, agree on a universal duty of mutual respect as the grounding principle of justice in response to global injustices such as global poverty and the GHC[282]. However, Miller grounds his theory primarily on the criterion of citizenship, justifying the precedence of citizens over non-citizens, and thus the precedence of duties of social justice over the duties of global justice. Eleftheriadis, on the other hand, argues against this necessary priority by showing the unreasonableness of this criterion alone. As Eleftheriadis puts it:

> a general argument for political obligation based on the status of citizenship alone fails to give an adequate account of outsiders. And this failure must be a reason to doubt the cogency of the citizenship theory of political obligation as a whole. If political obligation relies on citizenship and exclusivity […] then any international obligation seems impossible.[283]

However, Miller insists on the reasonableness of citizenship as a sufficient criterion to justify the limits of remedial responsibilities for global poverty: when asked about those difficult situations in which the domestic duty to promote social justice conflict with the global responsibilities to promote global justice, Miller insists that it is not plausible to

[282]Both would agree, therefore, on our framework for the responsibility to respect the right to health, encompassing the duty not to violate the right to health, and the duty to remediate its violation, such as the violations entailed by the GHC. (See chapter 2 for the discussion on the right to health and its corresponding duties.)

[283] Eleftheriadis, 2011, p.20

give strict priority to global duties over the domestic duties owed to fellow-nationals. He illustrates this point with the example of a pandemic flu:

> Suppose that a pandemic flu breaks out and the government has only sufficient vaccine to inoculate a limited number of vulnerable people against the disease. It does not seem wrong in this case to give priority to treating compatriots, that is to supply the vaccine to all those fellow-citizens identified by age or other relevant criteria as belonging to the vulnerable group, before sending any surplus abroad, even though it is reasonable to assume that some foreigners will be *more* vulnerable to the flu than some compatriots selected for the vaccination. And this remains true even if we know that those more vulnerable foreigners will not receive the vaccine from their own health services.[284]

For Miller, then, compatriots' basic health needs would necessarily have precedence over foreigners' same basic health needs, in the context of a common problem, such as pandemics, which are, by definition, an epidemic with global scale, and thus a potential global catastrophe. Given that the GHC is likewise a global catastrophe (as I will argue in chapter 4), it seems like that Miller would argue that compatriots' basic health needs would necessarily have precedence over the basic health need of foreigners, just as domestic duties of social justice prevail over and above global duties of justice.

3.1.3. Citizenship, Duties of Justice, and Reasons for Benevolence

[284] Miller, 2007, p.45

Miller actually concedes an exception to his premise on the necessary priority of citizens over non-citizens: developed nation-states and their wealthy citizens bear a duty of global justice that could justifiably take precedence over their domestic obligations of social justice if and only if (i) wealthy nations are outcome responsible for their poverty (the causes of world poverty are a direct outcome of wealthy nations' conducts and policies), and (ii) there are global institutions in place, able to enforce the discharge of said duties. Only under these two conditions can the global remedial responsibilities for the basic needs (i.e. basic rights of subsistence) of the global poor take precedence over domestic responsibilities of social justice[285]. Miller argues as follows:

> Suppose, at one extreme, that world poverty was entirely the (outcome) responsibility of rich societies and their governments. Then the citizens of those societies would have remedial obligations that might well trump their internal obligations of justice (such as their obligation to create and support an extensive welfare state). Moreover these obligations would be enforceable […] At the other extreme, suppose that rich societies were in no way responsible for global poverty; it was entirely endogenous to the poor societies. In that case, remedial responsibilities would be humanitarian only, and would therefore take second place to domestic duties of justice. They would also not be enforceable by third parties. Neither of these extremes describes the world as it actually exists. But to know what we owe to the world's poor, we have first to come up with a more accurate, and therefore more discriminating, account of the underlying causes of poverty.[286]

[285] Ibid, pp.259-261

[286] Ibid

Importantly, the crucial distinction between duties of justice and reasons for benevolence carries much of the normative burden in Miller's argument. The duty to help the global poor does not have priority over the duties the state has toward its citizens, Miller thinks, precisely because it is the former that, on Miller's account, constitutes a mere duty of benevolence, while the latter is a necessary duty if the principle of justice is not to be transgressed. Thus for Miller, humanitarian duties are less weighty than are duties of justice'[287]. Likewise, whilst Miller acknowledges that duties of justice can be strong enough to reverse the *prima facie* priority that each nation-state owes to its own citizens, reasons for benevolence have no such strength. As a result, when it comes to discerning the precedence of certain remedial duties towards the global poor, the most fundamental distinction – which ultimately carries the decisive burden of Miller's argument -- is not, as he presents it, the differentiation of citizens and non-citizens, but rather a distinction of duties of justice from reasons for benevolence.

The governing principle of Miller's views on remedial responsibilities for global poverty is not, therefore, the distinction between citizens and non-citizens (as Miller presents it *prima facie*). Rather, the distinction that does the most 'moral reasoning' is the principle that differentiates duties of justice from reasons for benevolence: Miller's argument is grounded by the axiomatic priority of duties of justice over reasons for benevolence. Consistent with this, Miller advocates the general priority of citizens as a general rule (consonant with the state's duties owed in justice), but he concedes an exception for this general rule when two conditions apply (namely outcome responsibility and existence of institutions). Crucially, it is the distinction between duties of justice and deeds of

[287] Ibid, p.248

benevolence that underpins both the general rule in Miller's theory and also its exception: as such, this critical distinction between duties of justice and reasons for benevolence carries the entire burden of the moral work in Miller's theory. First, it justifies the general rule because, according to Miller's view, there are duties of justice towards citizens, and reasons for benevolence towards non-citizens. Second, it justifies the exception because, according to Miller's view, the cases allowed by the exception are precisely the cases where there is in fact a duty of justice towards non-citizens. *In sum*, Miller's theory is not ultimately grounded in the priority of citizens over non-citizens, but rather in the priority of duties of justice over reasons for benevolence, which generally justifies the principle that citizens have priority, but can at exceptional times justify giving precedence to non-citizens, in the conditions that Millers explains.

This first section has discussed Miller's theory of global justice because it provides a clear philosophical account of what I have called 'the conventional account of public international law'. Both Miller's theory and the conventional account of public international law are state-centered: they focus on the concept of the nation-state and the related idea of citizenship. The conventional account of public international law supports the view that states are the exclusive subjects of international law, and as such posits that each state bears human rights responsibilities for its own citizens, as well as humanitarian aid responsibilities for outsiders (i.e. citizens of other nations). This notably matches Miller's conclusions on remedial responsibility for global poverty: the state has, first and foremost, a duty of justice towards its citizens, and then a humanitarian duty of benevolence to aid the non-citizens in poverty.

The source of the controversy, therefore, is the question of whether states and their citizens have duties of justice towards those with whom they are not linked through

bonds of citizenship, and, if so, whether the duties of justice towards citizens have priority over the duties of justice towards non-citizens. Miller's account provides an answer by introducing the two further requirements mentioned above, namely 'outcome responsibility' of wealthy nations and citizens, and existence of institutions to enforce the remedial duty. There is a need, however, to develop an account of these two further requirements, especially in the context of the GHC. It is not immediately apparent in Miller's theory, for example, why there is a remedial duty of justice when institutions exist, and why, on the contrary, there is no duty of justice when these institutions do not exist. Presumably, when there are no institutions to enforce a duty, there is a moral duty of justice to attempt to build such institutions, or to attempt to fulfill the obligations as much as reasonably possible, even through non-institutional means.

The duty to build or reform institutions so that certain remedial duties of justice may be discharged is the final aim of Pogge's theory. The next section discusses Pogge's theory of global justice. Miller's and Pogge's views are complementary in many aspects. Both discuss the responsibilities that we have for the global poor in terms of a collective or institutional responsibility. Pogge builds on Miller's six criteria, and further explains those six questions of morality, outcome, causality, benefit, capacity, and communal connections when he argues for our duties for the global poor and ill. As we shall see, Pogge draws further relevant distinctions, which will be an essential means of setting the priorities for a more reasonable and politically feasible response to global poverty, and to the GHC in particular. In this way, Pogge's account of justice can serve as helpful signal resource, indicating further points at which the current conventional approach to international law of human rights stands in need of systemic reform.

3.2. Pogge and the cosmopolitan approach to public international law

In this section I use Pogge's theory, which develops Miller's theory and discusses the six criteria for remedial responsibilities, to further explore questions on global injustices and global-poverty-related ill-health. Although Pogge does not offer an extended treatment of the distinction between general 'remedial responsibility' and 'outcome responsibility' in the way Miller does, Pogge does nonetheless engage with these categories, dealing with aspects concerning all of the six criteria that Miller enumerates.

Although Pogge does not deny the primary responsibility of states in relation to their citizens, he challenges Miller, and thus implicitly questions the conventional state-centric approach to international law of human rights in two ways: firstly, he argues against the necessary priority of the responsibilities of justice for citizens, arguing instead for the priority of the duty, in justice, to reform existing institutions when these institutions produce unjust outcomes over the global poor; secondly, by arguing against the necessary priority of citizens over non-citizens, Pogge further challenges the conventional state-centric approach to international law of human rights by arguing that all global players, state and non-state actors alike, share human rights and global justice responsibilities for the global poor. Whereas the conventional state-centric approach to international law of human rights stipulates that states are the exclusive subjects of international law Pogge's institutional theory of global justice argues that all global players – state and non-state agents alike – bear certain human rights responsibilities of justice for the global poor. Likewise, Pogge argues that these responsibilities of justice for non-citizens (distant strangers dying in poverty, *inter alia*) have priority over citizens' claims that are not claims of justice.

Pogge puts forth his cosmopolitan view of justice, according to which all global players share certain human rights responsibilities for global poverty, by arguing against Miller's theory on the necessary priority of citizens over non-citizens. Therefore, I will first provide a general comparison of Miller's and Pogge's views on the remedial responsibility for global poverty and the question of citizenship (in section 3.2.1). Then, in section 3.2.2, Pogge's theory of global justice, based on his ideas of institutional causation, connection, and contribution, is introduced in detail. Finally, section 3.2.3 discusses further how his ideas of institutional causation, connection, and contribution apply directly to his claims against Miller, the priority of citizenship, and the conventional view of public international law. Pogge shows how his claims apply by drawing six scenarios, in which he contrasts and explains the different moral responsibilities that global players bear to one specific problem concerning public health.

3.2.1. Miller vs. Pogge on remedial responsibilities for global poverty

Both Miller and Pogge discuss global justice and world poverty under a 'relational' and an 'institutional' perspective. Both theories explore the different nuances of responsibilities for global poverty by analyzing the different relationships between a certain institution (or individuals within this institution) and the global poor. While Miller emphasizes the role of domestic institutions and domestic connections in the causation of poverty, Pogge emphasizes the role of global institutions and global connections.

Focusing on domestic institutions and domestic relations, Miller argues that domestic actors bear the primary responsibility for their local situations. Miller, therefore, emphasizes that the national roots and domestic causes for injustices should always be scrutinized before any claim on global remedial responsibilities is made. According to

Miller's analysis, local corrupt elites, inefficient bureaucracies, week public political culture, and other historical factors are indeed the main systemic defects and the main reasons for the perpetuation of severe poverty worldwide. Consequently, as global poverty is largely engendered by disastrous domestic structures, Miller argues that it is reasonable that these local corrupt elites and oppressive governments be made fully accountable for the needs of their poor citizens in dire situations. For Miller, in this case, outsiders can only aid to a limited extent: up to the limit of their humanitarian duties of benevolence to aid non-citizens in poverty, and it would be unreasonable and morally unacceptable, according to Miller, to intrude on a nation's sovereignty, and interfere in its internal political affairs.[288]

Pogge does accommodate this claim, adding that such an intrusion into a nation's sovereignty could understandably prompt counter-reactions that tentatively interpret the intrusion as a supposed new form of colonialism or imperialism.[289] Pogge agrees with Miller that the local institutions and corrupt elites are often the chief responsible agents for perpetrating the poverty of many developing countries. Pogge also agrees with Miller on the importance of scrutinizing the root causes of global poverty. But he is more skeptical than Miller of explanations that attribute the responsibility of global poverty solely to internal factors:

> The eradication of poverty in the poor countries indeed depends strongly on their governments and social institutions […] But this analysis is nevertheless ultimately unsatisfactory, because it portrays the corrupt social institutions and

[288] Miller, 2007, pp.238-247

[289] Pogge, 2008, p.117

> corrupt elites prevalent in the poor countries as an exogenous fact […] An adequate explanation of persistent global poverty must not merely adduce the prevalence of flawed social institutions and of corrupt, oppressive, incompetent elites in the poor countries but must also provide an explanation for this prevalence.[290]

Pogge argues that the global institutions and policies that significantly contribute to the shape of national institutions and policies provide the complementary explanation for such prevalence. For Pogge, therefore, there is an intense correlation between the global and national realms. If it is widely accepted that domestic systemic factors, institutions and policies unavoidably play a crucial role in the persistence of a country's poverty, it cannot, on the other hand, be reasonably denied, Pogge thinks, that the global economic order also play a substantial causal role by influencing how these domestic institution and national policies have been evolving. The current global economic order affects and shapes national cultures, identities, and preferences; it dictates domestic economic growth and income distribution; and it structures the general domestic institutional architecture. For Pogge, this is not questionable: the correlation is an existing fact, which cannot be artificially overlooked.[291]

For Pogge, the existing global economic order shapes and influences the incidence of poverty worldwide by determining global inequalities of both wealth and power.[292] These global economic institutions also considerably shape and influence the incidence of

[290] Ibid

[291] Ibid, pp.118-122, particularly p.121

[292] Pogge, 'Responsibilities for Poverty-Related Ill Health', in *Ethics and International Affairs*, 16:2, 2002, 71-79, pp.73-4.

certain medical conditions worldwide, which Pogge calls 'global-poverty-related ill-health'. These specific medical conditions are intrinsically linked to poverty because 'poverty is far and away the most important factor in explaining existing health deficits'.[293] Indeed, for Pogge, these specific medical conditions, linked to global poverty, are institutionally induced, particularly by those global economic institutions such as the TRIPs, which regulate the patents over medical knowledge, and dictate which medical conditions are most likely to have a cure and which are most likely to remain neglected.[294]

Pogge argues that these global-poverty-related diseases (which I am calling 'neglected diseases', as discussed in the introduction) are unjustly inflicted. As such, the existence of these unjustly inflicted poverty-related diseases justify the remedial responsibilities of wealthy states and wealthy citizens. However, if there are responsibilities of justice to remediate global-poverty-related diseases, and if these responsibility devolve onto the shoulders of wealthy nations and wealthy citizens, it remains unclear how these wealthy nations and wealthy citizens are causally connected to these diseases that the global poor suffer from.

Pogge's theory of institutional causation will receive extended treatment in section 3.2.1.1: *in nuce*, Pogge explains 'causation' under two relational factors, *viz.* 'connection' and 'contribution'. These twin relational factors seek to explain how wealthy nations and

[293] Poverty and ill health are intrinsically interrelated. The figures allow no doubt about such correlation: 'Because they are poor, 815 million persons are malnourished, 1.1 billion lack access to safe water, 2.4 billion lack access to basic sanitation, more than 880 million lack access to health services, and approximately 1 billion have no adequate shelter' (Ibid, p.72).

[294] See introduction, chapter 2 and chapter 5 on why the TRIPs has inflicted injustice on the global poor by worsening them off.

wealthy citizens are related to the diseases from which the global poor suffer. While 'connection' is shown by material involvement, 'contribution' is shown through an analysis of the shaping process of institutions. These factors are evident and intuitive when it comes to *conduct*: A has stronger moral reasons to help an accident victim if A is materially involved in the accident; and A has stronger moral reasons to make sure that others are not harmed through her negligence, than to make sure that others are not harmed through the conduct of B which is outside A's control. When it comes to *policies*, however, Pogge makes an analogous point 'in regard to any social institutions that agents are materially involved in upholding: in shaping an institutional order, we should be more concerned, morally, that it not contribute substantially to the incidence of medical conditions than we should be that it prevent medical conditions caused by other factors. Thus, we should design any institutional order so that it prioritizes the alleviation of medical conditions in which it substantially contributes'.[295]

For Pogge, we -- as wealthy individuals and as collectives politically organized in developed nations -- are all materially involved in the causation of poverty-related medical conditions worldwide. This is because we are all materially involved in upholding the existing global economic institutions, which have the greatest impact on poverty-related ill health.[296] Accordingly, because we are all supporting, encouraging and benefiting from both the global and the domestic economic orders, we have equally strong responsibilities that derive from the outcomes generated by both orders. As

[295] Ibid, p.71

[296] I discuss Pogge's argument on how the global economic order inflicts global poverty, and specifically how one particular global institution, namely the TRIPs, has been exacerbating the GHC, in the introduction of this thesis, as well as in chapter 2 and 5. Based on Pogge's theory, I argue that the current patent rules over medical innovation *exacerbate* or *aggravate* the neglected status of certain diseases for large parts of the world population.

Pogge puts it, we all 'have equally strong moral reasons to prevent and mitigate *compatriots'* medical conditions due to avoidable poverty engendered by *domestic* economic institutions as [we] have to prevent and mitigate *foreigners'* medical conditions due to avoidable poverty engendered by *global* economic institutions'[297].

Pogge here directly contradicts Miller's view on the priority of citizens over outsiders: Pogge argues that nationality/citizenship is a morally irrelevant criterion when we are assessing ill health inflicted by global poverty and global institutions. For Pogge, if a medical condition is perpetrated by an institutionally induced poverty condition, it does not matter whether the patient is a compatriot or a foreigner. Both poor-and-ill compatriot and poor-and-ill foreigner have had their illnesses inflicted by the economic order that we all support and benefit from both globally and nationally considered. Hence, we have equally strong moral reasons to prevent and mitigate their institutional-and-global-poverty-related pathologies (i.e. for both compatriots' and foreigners' poverty-related illness alike). According to Pogge, therefore, the poor-and-ill compatriot is morally on a par with the poor-and-ill foreigner.

Pogge's argument further challenges Miller's view by arguing that poor-and-ill foreigners should even be given precedence over ill compatriots when the medical condition of foreigners is institutionally-and-global-poverty-inflicted, and the medical condition of the compatriot is not (i.e. the compatriot disease is, for example, a result of brute bad luck or a natural and unavoidable health circumstance). As Pogge puts it: 'Foreigners' medical conditions, if social institutions we are materially involved in upholding substantially

[297] Ibid, p.79

contribute to their incidence, have greater moral weight for us than compatriots' medical conditions in whose causation we are not materially involved'[298].

Pogge therefore works here with two different ideas that require further unpacking: the first is his idea of institutional causation, connection, and contribution, where he opposes institutionally-inflicted ill-health and non-institutionally-inflicted ill-health; the second is the idea of citizenship, in which he opposes foreigners and compatriots. In the former, Pogge distinguishes the circumstances in which the principles of justice apply (due to the idea of institutional causation), and the circumstances where the principles of justice do not apply (due to the fact that the outcome is a result of brute bad luck or natural events). Regarding the latter, Pogge dismisses 'citizenship' as a relevant normative criterion, by arguing against the presumably special remedial responsibility that special communal memberships, such as citizenship, would justify.[299] Pogge concludes that 'such poverty-induced medical conditions among the global poor are, for us, morally on a par with poverty-induced medical conditions among the domestic poor, and of greater moral weight than not-socially-induced medical conditions among poor compatriots'[300].

Here again what seems to be doing much of the normative work on the most relevant moral distinctions is not the criterion of citizenship, but rather whether principles of justice apply to the situation or not: the strength of the moral claims of different

[298] Ibid, p.72

[299] In aiming to identify the agents who should be held responsible for the global poverty-related ill health, Pogge argues that, for this specific scope and purpose, the criterion of nationality/citizenship is a morally irrelevant one. The strength of the connection and thus responsibility that we globally share should not depend, in this particular case, on a matter of geographical proximity, or a political affiliation with a particular nation-state. Rather, it chiefly depends, as Pogge's relational theory supports, on an evaluation of causation, connection and contribution, focusing in an analysis of policies, conducts, actions and omission. (Ibid, p.71)

[300] Ibid, p.79

collectives (citizens and non-citizens alike) depends actually on whether they have a claim of justice or not.[301] If they have a claim of justice, they will get priority, regardless of their citizenship status. As such, Pogge argues against the irreducible priority of fellow citizens, arguing instead for the priority of remedial duties of justice to reform institutions that currently exacerbate global poverty, and which therefore inflict more misery on the global poor.

Below, I will further discuss these two ideas that are central to Pogge's theory, namely (i) 'institutional causation' that justifies duties of justice, and (ii) 'citizenship' that generate a duty of justice, and that justifies priorities for citizens in certain cases, but not in others. Pogge will comparatively discuss these questions in six different scenarios, where Pogge will explain the different moral responsibilities that different agents bear to one specific problem concerning public health.

3.2.1.1. Pogge on Institutional Causation and Duties of Justice

Pogge's theory plausibly explains the extent of our reciprocal responsibilities for the health conditions of others (whether compatriots or outsiders). His argument is chiefly grounded by the causal categories of 'connection' and 'contribution': the remedial responsibilities for poverty-related ill health are justified by the institutional connections we share with one another globally, and are limited by the extent of the contributions we institutionally make for the perpetration of such medical conditions. Both ideas of 'connection' and 'contribution' explain how we are causally related to one another, and thus how we are reciprocally responsible, to a certain extent, for one another's ill-health,

[301] In the previous section, we reached the same conclusion from Miller's theory.

when said ill health is an outcome of our institutional conducts (i.e. actions and omissions), and not an outcome of brute bad luck or natural defect.

Pogge formulates a more normativity-oriented explanation of his theory in *Relational Conceptions of Justice: Responsibilities for Health Outcomes*[302], where he attempts to identify and differentiate possible normative criteria for the circumstances of poverty-related ill health. Above all, when addressing these normative criteria, Pogge aims to identify who are the responsible agents, or, as he calls them, the 'agents of justice': those who have or share a moral responsibility for the justice or injustice of a certain circumstance[303].

In trying to respond to the question of 'who is/are responsible for [a situation's] injustice or for making it (more) just'[304], Pogge relies on what he calls an 'active' conception of justice that emphasizes the role of duty-bearers (i.e. responsible agents of justice), as opposed to a 'passive' conception of justice that emphasizes the right-holders as recipients of health care goods and services, to be fairly distributed.[305] This idea of active justice is crucial to Pogge's main argument for a relational conception of global responsibilities for global poverty-related ill health. This responsibility is relational in the sense that it is grounded on the relational and causal category of 'connection'.

[302] Pogge, 'Relational Conceptions of Justice: Responsibilities for Health Outcomes', in Anand, Peter, and Sen, *Public Health, Ethics, and Equity*, 2004, pp.135-161

[303] Ibid, p.143

[304] Ibid, p.143

[305] Pogge, 2007, p.75

Pogge's active conception of justice defines the responsibilities for poverty-related ill health in relation to both conduct and policies. The active conception of justice focuses primarily on how we relate or treat one another, and presupposes our natural duty of reciprocal respect (i.e. that we owe reciprocal respect to each other, as human beings with equal standing).[306] From this, Pogge argues that 'to be just is to give equitable treatment'[307], although the 'equitable' is not necessarily synonymous with the 'equal': 'equitable treatment' evaluates how subjects treat one another, and how agents of justice treat recipients. 'Equal treatment', by contrast, treats questions of how subjects ought to distribute health goods and services among recipients in the fairest possible way[308]. Pogge aims primarily to provide an answer to the first question. By focusing on 'equitable treatment' rather than equal distribution, Pogge's active conception of justice and responsibility focuses on the assessment of duty-bearers' conduct and policies, rather than, on the distribution of health care goods and services among the right-recipients.

Pogge's active and relational conception of responsibility, therefore, clarifies how we do justice (or perpetrate injustice), through an analysis of how we can treat one another justly (or unjustly). The distinction that Pogge draws between the justice based on inter-relations, and the justice based on distribution of health care goods and services is a morally relevant one. Although Pogge does not explicitly name them, he seems to be talking about the distinction between corrective justice, on the one hand, and distributive justice, on the other. The former provides reasons to rectify an unjust harm; the latter

[306] As discussed in the previous section, on the universal and natural duty of reciprocal respect, see also Eleftheriadis, 2012, p.24, and Miller, 2007, p.79

[307] Pogge, 2004, p.146

[308] This is, in essence, the divide in the debate on egalitarian liberalism (Ibid, pp.147-8)

provides reasons to distribute the common stock fairly. I will return to these ideas in due course.

3.2.1.2. Pogge on the Priority of Citizens over Non-Citizens

In his explanation of causal connection, Pogge outlines two arguments that contribute to his understanding of the moral relevance of an individual's citizenship. The first argument outlines when a medical condition of a foreigner is on a par with the same medical condition of a compatriot; by contrast, the second argument, explains when a medical condition of a foreigner and of a compatriot are not on a par. In other words, Pogge is demonstrating when the criterion of citizenship can be taken as morally relevant or irrelevant.

The first argument states the following:

> the more privileged adult citizens of affluent and reasonably democratic countries […] have equally strong moral reasons to prevent and mitigate compatriots' medical conditions due to avoidable poverty engendered by domestic economic institutions and to prevent and mitigate foreigners' medical conditions due to avoidable poverty engendered by global institutions.[309]

Pogge argues that (i) because the medical condition in both cases is institutionally induced (either by domestic institutions or global institutions), and (ii) because we -- 'the more privileged adult citizens of affluent and reasonably democratic countries' -- are

[309] Ibid, p.158

materially involved in upholding the economic order of our own society and also the global economic order, we cannot reasonably make distinctions solely on the basis of citizenship, political affiliation with a particular nation-state, or geographical proximity. It follows, then, that there is a remedial duty to rectify the injustices and compensate the victims of this injustice, which has been inflicted by those institutions we have upheld or benefited from; and the grounds of this remedial duty are exactly the same, whether the victims are compatriots or not, and whether the institutions that have afflicted the injustices are domestic or global. In both cases, we -- 'the more privileged adult citizens of affluent and reasonably democratic countries' -- share the same degree of moral responsibility for the institutionally-induced medical conditions of the poor, whether compatriot or foreigner. Therefore, according to Pogge's account,the criterion of citizenship is here not only morally irrelevant, but also morally arbitrary.

Pogge's second argument relates to the first, examining when a medical condition of a foreigner is not on a par with a medical condition of a compatriot. Here again, the criterion of citizenship is an irrelevant one:

> the more privileged adult citizens of affluent and reasonably democratic countries […] have stronger moral reason to prevent and mitigate foreigners' medical conditions due to avoidable poverty engendered by global economic institutions than to prevent and mitigate compatriots' medical conditions that are not due to mandated, authorized, or engendered deficits.[310]

[310] Ibid

In other words, the decisive fact that justifies the precedence of the ill foreigner over the ill compatriot in the second argument is the institutional connection/contribution to the foreigner's illness: here again the criterion of citizenship does no normative work.

To clarify his second and more controversial argument, in which he dismisses citizenship as a normative criterion, Pogge describes six different scenarios that show, he claims, an increasing moral weight: from the most morally stringent responsibilities of justice (scenario 1) to the least morally stringent (scenario 6). These scenarios illustrate the 'six basic ways in which a social order may have an impact on the medical conditions persons suffer under it'[311]. Pogge's six scenarios tackle the same medical pathology, whose avoidability is analyzed under six different institutional arrangements. The hypothetical medical condition that Pogge uses to discuss the six scenarios and to clarify the differences between them refers to 'the avoidable lack of some vital nutrients V', where:

> In Scenario 1, the nutritional deficit is officially mandated, paradigmatically by the law: legal restrictions bar certain persons from buying foodstuffs containing V.
>
> In Scenario 2, the nutritional deficit results from legally authorized conduct of private persons: sellers of foodstuffs containing V lawfully refuse to sell to certain persons.
>
> In Scenario 3, social institutions foreseeably and avoidably engender (but do not specifically require or authorize) the nutritional deficit through conduct they stimulate: certain persons, suffering severe poverty within an ill-conceived economic order, cannot afford to buy foodstuffs containing V.

[311] Ibid, p.156

> In Scenario 4, the nutritional deficit arises from private conduct that is legally prohibited but barely deterred: sellers of food- stuffs containing V illegally refuse to sell to certain persons, but enforcement is lax and penalties are mild.
>
> In Scenario 5, the nutritional deficit arises from social institutions avoidably leaving unmitigated the effects of a natural defect: certain persons are unable to metabolize V due to a treatable genetic defect, but they avoidably lack access to the treatment that would correct their handicap.
>
> In Scenario 6, finally, the nutritional deficit arises from social institutions avoidably leaving unmitigated the effects of a self-caused defect: certain persons are unable to metabolize V due to a treatable self-caused disease—brought on, perhaps, by their maintaining a long-term smoking habit in full knowledge of the medical dangers associated with it—and avoidably lack access to the treatment that would correct their ailment. [312]

These six scenarios aim to put forth Pogge's cosmopolitan theory of justice, essentially grounded by his ideas of institutional causation/connection/contribution. Pogge's scenarios, therefore, dismiss the priority of 'citizenship' as a relevant normative criterion, instead supporting his argument for the priority of remedial duty of justice (independent of considerations of nationality). Below, I evaluate Pogge's theoretical framework as evident in these six scenarios, focussing particularly on Pogge's above-mentioned ideas of institutional causation/connection/contribution in the context of the GHC.

I will, however, simplify the object of concern of these scenarios: instead of dealing with the nutritional deficits and the various specific and detailed ways in which the domestic

[312] Ibid

social institutions can impact the access to vital nutrients V, I adapt these six examples, in order to focus my analysis on how global, rather than domestic, institutions may impact on one particular medical condition M, either directly or indirectly. In my hypothetical situation, M is a medical condition that impairs the basic health needs of an individual; furthermore, M is a grave illness that can be easily and cheaply cured by the provision of the treatment M'; most significantly, M is an illness typical of the GHC, namely a neglected disease (as conceptualized in the introduction to this thesis). My suggested changes in the object of the six scenarios originally proposed by Pogge aim not only at simplification and at an easier understanding of the six different increasing moral weights defined by each scenario, but also at an easier identification of the fundamental moral distinctinctions at play within responses to the GHC, particularly when it comes to identifying the responsible global agents of justice.

Pogge's six scenarios provide an insightful framework for discerning the very different realities that justify the different degrees of justice and responsibility related to health needs. Nevertheless, because the original scenarios are high complexity and comprised of multiple, detailed, components, it is difficult to establish the most foundational comparisons, which provide the basis for a general contrast between scenarios. If we are seeking primarily to offer a clear understanding of our causal relations as global players (i.e. as individuals and as collectives) to the global poor in the context of the GHC it might be helpful to deal initially with the simpler scenarios that contrast only the degrees of connection and responsibility involving the same global agents in relation to the same medical condition M.

3.3. Application of Pogge's general framework to the GHC

In this section, I will adapt Pogge's original scenarios and apply them to the particular context of the GHC, in order to specifically identify the global players who have responsibilities to remediate the deprivation of basic health needs that the GHC inflicts.

In order to render the most fundamental comparisons among the re-interpreted scenarios consistent and coherent with the scope of global justice (rather than domestic/social justice), I will focus on the conduct and policies of global players (i.e. state and non-state actors alike), and I will only deal with the medical condition M. Therefore, no further details concerning the distributional aspects regarding the seller's conduct, the buyer's access to M', the differences in metabolisation of M', and the specificities of genetic defects, all of which were all originally cited by Pogge, will not be addressed. These detailed variables, as described by Pogge's original scenarios, are concerned with the evaluation of justice in the distribution of M', but are tangential to a more foundational consideration of the justice of the inter-relations of states and non-state global agents with the global poor. Indeed, these details are excluded insofar as they are peripheral to the precise question that I have identified as being of definitive significance: *viz.* the identification of the global agents of justice responsible for the global poverty-related ill health M?

My aim, therefore, is the exploration of this foundational aspect of justice as it relates to the GHC. I term this foundational type of justice 'commutative justice', borrowing the term from Thomas Aquinas. Commutative justice, as I define it here, provides a general framework within which the most basic principles of justice regulate the more specific dealings (particularly economic exchanges) between persons (i.e. individual agents), along with their general responsibilities of justice that arise from these inter-relations. As I define it, commutative justice provides a general framework, which can accommodate

contemporary understandings of justice and types of justice that convey a narrower and more specific discourse regarding corrective and distributive justice:[313] while the mainstream modern understanding of corrective justice essentially focuses on the question of the rectification of an originally just state of affairs that has been disrupted, and therefore on the question of the wrongdoer's duty to compensate for the victim's harm,[314] the mainstream modern understanding of distributive justice focuses on the question of social justice at the domestic context of welfare, concerned primarily with the fair distribution of resources (i.e. material goods, such as health care goods and services) by the state.[315] Therefore, the general principles of commutative justice, as I conceptualize them here, are not only compatible with the contemporary understandings of corrective and distributive justice, but also offers a philosophical grounding within which to locate these further principles of fairness in correction and distribution.

After a brief discussion of Aquinas' understanding of this general justice (i.e. commutative justice), I develop his conception, in order to outline what I will call 'Global Commutative Justice' (hereinafter GCJ): a general framework of the most foundational principles of global justice broadly ordering or regulating the inter-relations among individual global players. The purpose of calling this general framework by a distinctive name is to differentiate these different categories of justice: there is, on the one hand, a general framework of justice that focuses on the inter-relations among individual parts of

[313] The categories of corrective and distributive justice are widely known, dating back to Aristotle. Aristotle's *Nicomachean Ethics* (Book V) was the first to outline both concepts in general terms. Aristotle says that justice deals with either the exchange or the distribution of three things: honor, money, and security. It is in this context that he conceptualizes the two types of justice: the corrective justice that governs the exchange of these three things between one man and another, and the distributive justice that governs the fair division of these three things among men. Aquinas builds on Aristotle's conception of justice, and engages with Aristotle's two categories. Aquinas accommodates Aristotle's specific categories of justice, but he presents his view of justice in a slightly different way. Aquinas does not explicitly talk about the type of justice that Aristotle calls 'corrective'; but Aquinas's concept of commutative justice encompasses the idea of rectification of unjust wrongs, in the form of what Aquinas calls 'restitution', as we will see.

[314] See, for example, Coleman, *The Practice of Principle*, 2003

[315] Simmonds, 'Justice and Private Law in a Modern State' in *The University of Queensland Law Journal*, 2006, pp.229-252, p.238

a whole, and there is, on the other hand, a particular framework of justice that is narrower, and which focuses on particular cases of distribution from the whole to its the individual parts. The general framework of GCJ is distinct from this particular type, although they are obviously related insofar as the particular instances of justice derive from and can only be justified by reference to the unity of the general framework. Therefore, by naming and identifying this general framework of justice, it is possibly to qualify it, and thereby traces its foundational role in the generation of particular instances of justice requirements. Indeed, by qualifying the inter-relations among individual global players (state and non-state actors alike) by establishing their relation to the whole, the idea of GCJ fundamentally clarifies the responsibilities of justice that both states and non-state players have towards one another and towards the global common good[316].

3.3.1. Aquinas and GCJ

Aquinas first clarifies the general concept of justice as follows: 'justice directs a man in his relations with others […] others considered as individuals […] and others as

[316] It is worth noting that both Aquinas and Pogge explain justice as a relational concept that regulates how one person ought to treat others, thus establishing how one person can act justly or unjustly towards others. This is the common ground between Aquinas and Pogge: for both, justice concerns reciprocal inter-relations, and both focus their analysis on the inter-relations between individual parties. Yet, a relevant difference between them is that Aquinas explicitly acknowledges the difference between the two categories of justice, namely commutative and distributive justice, and Pogge does not explicitly mention or differentiate the two categories of justice when he presents his scenarios. Yet, Pogge does implicitly convey the difference between commutative and distributive justice, as he says that his scenarios aim to focus on matters pertaining how subjects relate and should treat other subjects in a poorer condition (in other words, commutative justice), rather than on matters pertaining how subjects ought to distribute certain goods to other subjects as mere recipients (in other words, distributive justice). (Pogge, 2004, p.135,146). However, Pogge does not make this division clear enough in his scenarios, and he actually conflates both realities of justice in his examples. This is why I have made this distinction explicit here, and have emphasized the moral distinctiveness of commutative justice as the most foundational principles of justice regulating in broad terms the general mutual dealings between individual players. So by differentiating the general principles of commutative justice, on the one hand, and the particular principles of distributive justice, on the other, I aim to avoid conflating their different claims in my proposed reformulated scenarios. I also aim to thereby be able to spot only the most foundational moral issues at stake regarding the remediation of the GHC, such as who the agents are bearing remedial responsibilities of justice for the GHC.

belonging to the community'[317]. This general justice orders the conduct of one particular person to another, by consistently directing them towards the common good of the whole community. This general concept of justice, which orders the conducts of individual parts towards the common good of the whole community, is called commutative justice.[318] This commutative justice, then, regulates the conduct of individual parts in relation to each other and in relation to the whole, for the sake of the common good of the whole. That is to say, principles of commutative justice regulate in general terms how one individual person ought to treat another within a shared community, as a matter of rights and what is owed to the other, by ordering, directing, and harmonizing inter-personal relations in accordance with the common good of the whole[319]. As Aquinas puts it:

> Justice directs a man in his relations with others. These fall under two heads, those with others considered as individuals and those with others as belonging to the community, inasmuch as he who serves the community serves all who come within it. Consequently, justice in its proper meaning can cover both. Now clearly all who are contained in a community are related to it as parts to a whole. A part as such belongs to a whole, so that any good of the part can be subordinate to the good of the whole. Accordingly, the value in each and every virtue, whether it composes a man in himself or whether it disposes him in relation to others, may be referred to the common good, to which justice order us. In this way, the acts of all the virtues can belong to justice in that it orders a man to the common good. It is in this sense that justice is called a general virtue. And since it is for the law to regulate for the common good, such general justice is called legal

[317] *ST* ii.ii q.58, a5
[318] Ibid.
[319] See Finnis, *Aquinas – Moral, Political, and Legal Theory*, 2004, p.188

> justice, for thereby a person accords with law which directs acts of all the virtues to the common good.[320]

The general virtue of justice, according to Aquinas, encompasses two spheres of consideration: there is the common sphere (referring to the community and to the common good), and there is the individual sphere (referring to each individual person as part of the whole community, and their free moral actions). General justice, in essence, orders all individual moral choices and conduct, in addition to the communal decisions reflected in policies and patterns of behavior that are ordered towards service of the common good of the whole human community. This general concept of justice is also known as legal justice, because it is the task of the law to regulate, coordinate and harmonize individual conduct and communal policies towards the common good of all.

Commutatio in Latin means 'change'[321], and as such commutative justice regulates inter-personal exchanges (or moral 'transactions') that are ordered towards the common good of the whole community.[322] For Aquinas, commutative justice relates one individual part to another, and therefore secures each individual part within the framework of the common good of the whole: the logic of 'commutative justice', therefore, moves in a bottom-up direction, connecting the particular individual circumstance to the universal principles that govern the whole collective. Distributive justice, by contrast, proceeds in an opposite direction, relating 'the whole to the part' in a top-down move, ordering the fair distribution of the common stock among the parties of the whole. As Aquinas puts it:

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[320] *ST* ii.ii, q58, a5
[321] Finnis, 1980, pp.178-9
[322] The idea of reciprocity is relevant in differentiating commutative and distributive justice, because 'in distributive justice such reciprocity has no place'. (*ST* ii.ii, q61, a4)

> We may note a twofold relationship. First, that of one part to another, and this corresponds to the ordering of private persons among themselves. This is governed by commutative justice, which is engaged with their mutual dealings one with another. Second, that of the whole to a part, which goes with the bearing of the community on individual persons. This is governed by distributive justice which apportions proportionately to each his share from the common stock. And so there are two species of justice, namely commutative and distributive justice. […] A movement gets its character from the term it arrives at. Accordingly general or legal justice aims to conduct the dealings of private persons to the good of the community, whereas the reverse holds when that is brought to private persons; such distribution is a function of particular justice.[323]

Accordingly, Aquinas acknowledges two categories of justice: one that points upwards, towards the common good of the whole, and the other that operates in the opposite direction by distributing from the common stock to its individual parts. The former category Aquinas calls commutative justice; and the latter he calls distributive justice. It is worth noting that Aquinas' notion of commutative justice is broad, reflecting a much more general and all-encompassing scope than Aristotle's idea of corrective justice[324].

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[323] *ST* ii-ii, q61, a1

[324] Finnis explains that Aquinas actually replaces the narrower notion of 'corrective' for the broader notion of 'commutative', because the term 'corrective' can be misleading: it can lead to an understanding of justice that exclusively deals with the duty to compensate the victim and restitute her loss:

> The real problem with Aristotle's account is its emphasis on correction, on the *remedying* of the inequality that arises when one person injures or takes from another, or when one party fulfils his side of a bargain while the other does not. This is certainly one field of problems of justice, but even when added to the field of distributive justice it leaves untouched a wide range of problems. 'Correction' and 'restitution' are notions parasitic on some prior determination of what is to count as crime, a tort, a binding agreement, etc. So it was that Thomas Aquinas purporting to interpret Aristotle faithfully, silently shifted the meaning of Aristotle's second class of particular justice, and invented a new term: 'commutative justice' […] But the advantage of Aquinas's new term is precisely that, in his usage, it is limited neither to correction nor to voluntary or business transactions, but is almost as extensive as the term *commutatio* in Latin (='change'), limited only by its contextual restriction here to the field of human interaction'. (Finnis, 1980, p.178-9)

Aquinas' commutative justice in fact accommodates and contains the Aristotelian concept of corrective justice, but goes beyond it: Aquinas addresses the issues of correction or remediation of injustices under the rubric of 'restitution', as we will see below. However, 'restitution' is but a single aspect of his broader concept of commutative justice.

In sum, as Aquinas conceptualizes it, commutative justice comprises a set of the most general principles of justice regulating the mutual dealings (particularly economic exchanges) between individual parties in relation to the common good of the whole community. In view of that, what I am calling here GCJ mirrors Aquinas' idea of commutative justice, applicable to the current global institutional order and to the economic exchanges between global players, in particular those regulated by the TRIPs.

The key principle that governs this idea of GCJ is the recognition that both individuals and collectives – including those that do not have jurisdiction over a particular community (i.e. both non-state global players, as well as states at the global level) -- have responsibilities of justice that arise simply as a result of their common membership of the international community. Specifically, this highlights the human rights responsibilities of non-state actors towards the global common good (given that the human rights responsibilities of states are uncontroversial). As discussed in the previous sections of this chapter, both the conventional and the cosmopolitan views of public international law agree that remedial human rights duties fall primarily on one specific subject: the state. Yet, as the cosmopolitan view adds, if the state does not discharge its remedial duties, this will then fall on the shoulders of all other global players (state and

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So, the general framework of commutative justice encompasses the more specific idea of corrective justice. Although Aquinas does not explicitly employ the term 'corrective' justice, his framework of commutative justice includes the more specific and narrower idea of 'restitution'.

non-state actors alike), and on the global order as a whole, for the sake of the global common good. This cosmopolitan claim, I argue, mirrors Aquinas's commutative justice framework, as applied to the contemporary global order, and for this reason I term it GCJ[325].

This GCJ therefore supports the cosmopolitan approach to public international law, according to which all global players (state and non-state actors alike) ultimately share human rights and global justice responsibilities, particularly the duty to remediate the injustices related to the GHC, towards *citizens and non-citizens alike*. The scenarios below are grounded on this understanding of GCJ. Yet, two clarifications here need to be made: the first relates to the emphasis on remediation, and the second relates to the question of prioritization of citizens.

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[325] GCJ, as I am presenting it here, is concurrent not only with the existing cosmopolitan view of public international law; it is actually concurrent with its foundations –*ius gentium. Ius gentium,* also known as the Law of Nations, is particularly relevant in the context of *ius inter gentes*, namely public international law. *Ius gentium* is actually the root of public international law, as it lays out the universal principles of commutative justice.

For Aquinas, *ius gentium* is a universally applicable positive law that derives immediately by deduction from natural law; it applies universally across jurisdictional boundaries, being thus cosmopolitan (ST i-ii, q.95, a.2; ST ii-ii, q57, a3). So, the authority of *ius gentium* derives both from natural law and the human (global) institutions that derive directly from natural law. Finnis adds that *ius gentium* derives from natural law, being thus part of natural law (See, Finnis, 1980, p.296). For Maritain, *ius gentium* (represented by the charter of rights of the League of Nations – the UN predecessor) derives from natural law, in the same way conclusions derive from premises Maritain describes *ius gentium* (and the charter of rights belonging to it) as rational conceptualizations of an instinctively known natural law (Maritain, *Man and the State*, 1951, p.98).

In the current public international law parlance, my idea of GCJ could also be translated to the so-called 'principle of international solidarity'. International solidarity is a principle of justice, which is thus different from international humanitarian aid as a benevolent assistance or charity. I will discuss the differences between justice and charity in greater detail in chapter 5, but by now it suffices to say that the principle of international solidarity, as a principles of (global) justice – or, to be more precise, as a principle of GCJ, as I call it – orders the international relations among global players towards the global common good of peace, justice and integrity of the global order. The UN conceptualizes the principle of international solidarity clearly echoing Aquinas' framework of commutative justice. As the draft declaration on international solidarity puts it:

> International solidarity is not limited to international assistance and cooperation, aid, charity or humanitarian assistance; that it is a broader concept and principle that includes sustainability in international relations, especially international economic relations, the peaceful coexistence of all members of the international community, equal partnerships and the equitable sharing of benefits and burdens (Doc.UN.A/HRC/26/34/Add.1, *Report of the Independent Expert on human rights and international solidarity, Virginia Dandan – Preliminary text of a draft declaration on the right of peoples and individuals to international solidarity*, Preambular paragraphs, 1April2014).

Firstly, in order to establish the responsibilities of justice that individual global players have towards one another, and towards the global common good, in the context of the GHC, the scenarios will analyze the different relations and responsibilities of individual global players among themselves and towards the global poor in particular. The emphasis on the global poor is the reason why the scenarios emphasize one specific aspect of GCJ, namely the remedial duties of justice. This is not, nevertheless, to imply that the principles of GCJ are limited to the correction/remediation of injustices. Again, the idea of GCJ encompasses the idea of corrective justice, but goes beyond it, by referring to the primary responsibility towards the global common good.

Accordingly, in justifying the need for correction or remediation of the injustices towards the global poor, the principles of GCJ reinforce the primary responsibility towards the global common good of the whole. Hence the idea of GCJ is better suited to the purposes of this thesis than is the narrower idea of corrective justice. As discussed in chapter 2, the object of this thesis is establishing the responsibility to respect the right to health, in the specific context of the GHC.

As presented in chapter 2, this is a two-fold responsibility: first, all global players have a duty not to violate the human right to health of others, by avoiding the imposition, maintenance or creation of institutions that generate an avoidable insecurity of access to basic health needs; and, secondly, global players have a duty to remediate violations of the previous duty. Although the GHC appeals more straightforwardly to the need of remediation, such duty to remediate derives from, and is part of, the primary responsibility to respect the right to health, which is necessarily a responsibility towards the global common good for the whole. In other words, although the GHC (and the

scenarios below) focuses on remedial duties, I am highlighting that these responsibilities derive from, and are part of, the responsibilities towards the global common good, and they seek therefore not the mere correction of wrongs.

Second, according to the cosmopolitan view of public international law, there is no reason why responsibilities to remediate institutionally-inflicted harms done to citizens would have priority over responsibilities to remediate institutionally-inflicted harms done to non-citizens, *ceteris paribus*. As argued above in section 3.2.1, Pogge (and the cosmopolitan view of public international law) dismisses the priority of citizenship as a valid normative criterion, arguing instead for the priority of remedial duties to reform institutions currently exacerbating global poverty, such as TRIPs-related institutions. So, in adopting Pogge's argument supporting the cosmopolitan view of public international law, I also dismiss the priority of citizens over non-citizens as a relevant criterion to analyze the inter-relations among global players in relation to the global poor and the global common good; instead, I will, as Pogge does in his scenarios, focus on the priority of duties of justice over reasons for benevolence.[326] As we shall see below, this will be reflected in scenarios 1, 2, 3 and 5, where the remedial principles of GCJ apply. By contrast, in scenarios 4 and 6, the remedial principles of GCJ do not apply, although the greater principles of benevolence do.

The discussion of Pogge's scenarios, enlightened by Aquinas' scenarios and his principles of commutative justice, will serve to clarify what duties different global players, individually considered, have towards the global poor. The principles of GCJ, *in sum*,

[326] As discussed in the previous sections of this chapter, the priority granted by the conventional approach of public international law to the demands of citizens was premised on the view that responsibilities towards citizens are a matter of justice, whereas responsibility for non-citizens are a matter of benevolence (See Miller, 2007). Hence, the priority of the former. But once it is established that there are responsibilities of justice towards non-citizens, then the reasons according to which the conventional view grants a general priority to the demands of citizens do not hold anymore.

establish that individual global players have individual responsibilities of justice (such as remedial duties of justice) towards the global common good, and thus towards the global poor. The individual duties of one specific global player particularly relevant in the context of the GHC (namely pharmaceutical firms) will be discussed in chapter 4. In this chapter, however, I will discuss the different possible ways in which global players (state and non-state actors alike) can have remedial duties of justice to the global poor in relation to the GHC. These are the six scenarios. My discussion of the scenarios will therefore support and further explain the cosmopolitan view of public international law, which considers all global players to be responsible in a way and to a certain extent for global poverty.

Since my proposed reformulated scenarios are a development of Pogge's six scenarios, critically assessed on the grounds of Aquinas' nine scenarios, I will first (in section 3.3.2) introduce Aquinas's scenarios, and quickly relate each of them to their respective scenarios in Pogge's framework, and then (in section 3.3.3) present my re-interpreted scenarios, based on the discussions on Pogge and Aquinas.

3.3.2. Aquinas's nine scenarios of causation vs. Pogge's six scenarios of causation

Aquinas' account of causality is very pertinent for the purposes of this thesis and to this chapter in particular. Aquinas explains his ideas of causation, by providing examples of nine different scenarios, and each will spell out a caution 'factor', as he calls it. Aquinas' scenarios prove to be very useful complement in the critical discussion and further clarification of Pogge's six scenarios. Aquinas discusses the different scenarios of causation in the general context of commutative justice. This means that all of his nine scenarios will ultimately aim to secure or to restore a just relationship between individual

parties, while also serving the common good of the whole; this will be particularly evident in Aquinas' scenarios involving a remedial duty, or as he calls it 'restitution'. In my re-interpretation of Pogge's six scenarios, I therefore engage with certain relevant aspects that emerge from Aquinas's nine scenarios, which are outlined *in nuce* below.

First of all, for Aquinas, there are direct and indirect forms of causation. An injustice or harm is directly caused, either by actions or omissions, in six of the Aquinas' scenarios: *command, consent, advice, flattery, shelter, and taking part*. In addition to these direct causal categories, an injustice or harm may be indirectly caused, most commonly by omission, such as when, for example, someone 'does not stop the wrongdoer when he could and should' or when 'he denies help which would have halted' the injustice. Basically, an injustice can be indirectly caused, according to Aquinas's framework, by *keeping dumb, not preventing, or not revealing*, which consists of the remaining three Aquinas's scenarios of causation.

Out of these nine scenarios, in which Aquinas presents nine different causation 'factors', five can justify 'restitution', meaning here a duty to remediate an injustice that has been inflicted. This concept of 'restitution' is particularly relevant for our purposes, because it is by use of this concept that Aquinas will develop his ideas on causation, connection and contribution in the context of his idea of commutative justice, which proves to be helpful in further discussing Pogge's idea of institutional causation, connection and contribution, in the context of the GHC.

'Restitution', for Aquinas, is the remedy through which commutative justice restores the due balance in relationships. Restitution is justified by the reciprocity within relationships; reciprocity justifies restitution because it shows the causal connection within a particular

situation: there can only be restitution if there is reciprocity between the doer and the sufferer in relation to the same injustice[327]. 'Restitution' is, therefore, more directly concerned with the form of justice that is corrective, in the Aristotelian sense. As Aquinas puts it: 'the remedy is supplied by restitution, which redresses the balance; here it is enough that a man restore just as much as he has belonging to another'[328]. Although restitution may emphasize the correction of an injustice, it can only be fully understand in the general context of commutative justice, where not only the reciprocity between individual parties is restored, but also the harmony with the common good of all is secured[329].

The idea of restitution is key to law, and to private law in particular. Private law (property rights law, contract law and tort law, for example) is grounded on the ideas of reciprocity and rectification of injustice: there is a reciprocal relationship between the defendant and the plaintiff, as the doer and the victim of an injustice[330]. The defendant caused harm to the plaintiff, and a remedy is required to restore the justice in their relationship. In order to do so, however, law demands that, among other things, the legal causation -- meaning the connection between the defendant, the plaintiff, and the harm -- be fully explained[331].

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[327] *ST* ii-ii, q61, a4

[328] *ST* ii-ii, q62, a3

[329] For Aquinas, 'restitution is an act of commutative justice' (*ST* ii-ii, q62, a1)

[330] See Gordley, *Foundations of Private Law – Property, Tort, Contract, Unjust Enrichment*, 2006

[331] See Weinrib, 'Corrective Justice in a Nutshell', in *The University of Toronto Law Journal,* 52:4, Autumn, 2002, 349-56, pp.350, 355.

See also Owen, 'Why Philosophy matters to Tort Law', in Owen, *Philosophical Foundations of Tort Law*, 1997, pp.1-9.

Five out of nine Thomistic scenarios justify restitution: *command*, *consent*, *shelter*, *taking part*, and *not preventing*. As Aquinas puts it:

> Note that five of these [nine causation factors] always set up an obligation to make restitution. First, command, for he who gives an order is the prime mover, and so he principally is bound to restitution. Secondly, consent, namely the approval of him without whom the injustice could not be committed. Thirdly, shelter, as with one who harbours thieves and offers them protection. Fourthly, taking part, as with one who shares in the villainy and the spoils. Fifthly, not preventing, that is, when one is bound to do so, and this applies to those officers who are charged with maintaining justice in the land; if they fail in this duty, to which a salary is appointed, and thieves increase and prosper, they are bound to restitution.[332]

Each of these five Thomistic scenarios correlates to some of Pogge's scenarios as it follows:

(i) Aquinas' scenario of *command* is equivalent to Pogge's first scenario of an *official mandate*. An injustice that has been *officially mandated* has been *commanded*, and as such it does, according to Aquinas, justify restitution, meaning a duty to remediate the unjust situation. For Pogge, too, it justifies a rectification.

(ii) Aquinas' scenario of *consent* corresponds to Pogge's second scenario, where the injustice is *authorized by the law*. *Consenting* to an injustice is equivalent to

[332] *ST* ii-ii, q62, a7

authorizing it: for both Aquinas and Pogge, this situation justifies a duty to remediate the injustice.

(iii) Aquinas' scenario of *shelter* corresponds to Pogge's scenario 3, where social institutions engender an injustice 'through the conduct they stimulate'[333]. For Aquinas, *shelter* conveys the idea of providing 'protection' or 'any other kind of help' as a way of supporting and stimulating an injustice[334]. In other words, by *shelter* Aquinas means being complicit[335] in an injustice as a way of supporting it. So, Aquinas' idea of s*helter* resonates with the idea that Pogge conveys in his scenario 3, where an avoidable injustice is supported and stimulated by institutions' conducts and policies.

(iv) Aquinas' scenario of *taking part* correspond to Pogge's scenarios 3 and 5, where the injustice is 'avoidably engendered' or 'avoidably left unmitigated'. For Aquinas *taking part* conveys not only the idea of 'sharing in [the injustice] as an accomplice in the wrongdoing'[336]; it also conveys the idea of 'sharing in the

[333] Pogge, 2004, p.156

[334] *ST* ii-ii, q62, a7

[335] Ruggie has spelled out clearly the idea of complicity in the context of the contemporary view if public international law. Ruggie defines complicity in the particular context of transnational corporations; yet, the idea would also apply to other global players. In essence, complicity means an involvement in injustices and violation of rights, where such wrongdoing or harm has actually been committed by a third party. Being complicit therefore means sheltering a wrongdoing by providing practical assistance or encouragement. As Ruggie puts it:

> 73. The corporate responsibility to respect human rights includes avoiding complicity. The concept has legal and non-legal pedigrees, and the implications of both are important for companies. Complicity refers to indirect involvement by companies in human rights abuses - where the actual harm is committed by another party, including governments and non-State actors. Due diligence can help a company avoid complicity.
>
> 74. The legal meaning of complicity has been spelled out most clearly in the area of aiding and abetting international crimes, i.e. knowingly providing practical assistance or encouragement that has a substantial effect on the commission of a crime. (Doc.UN.A/HRC/8/5, para.73-74)

[336] *ST* ii-ii, q62, a7

villainy and the spoils'[337] resulting from the wrongdoing. Aquinas's idea of *taking part* is illuminating for my discussion, as he introduces an element that is central to our debate, but that has been overlooked in Pogge's scenarios: the benefit that one derives from an injustice committed by a third part. So, Aquina's idea of *taking part* goes beyond simply protecting, supporting and stimulating the wrongdoer by *sheltering* and *complicity* regarding his conduct; *taking part* also includes the idea of benefits and profit that the accomplice receives from his complicity[338]. As I will discuss below, both ideas of *shelter* and *taking part* are crucial in the context of the GHC.

(v) Aquinas' scenario of *not preventing* correspond to Pogge's scenarios 3, 4, 5 and 6, where the ill health is 'avoidably engendered' (scenario 3), 'barely deterred' (scenario 4), 'avoidably left unmitigated' (scenarios 5 and 6). In Aquinas' theory, a duty to remediate (i.e. 'restitution') arises from '*not preventing*, that is, when someone is bound to do so […] and fails in this duty'[339]. The content of Aquinas' duty to prevent an injustice seems to mirror the so-called 'duty to rescue', to be discussed in chapter 5. Both the Thomistic duty to prevent and the tort law duty to rescue involve, as I will discuss below, situations of 'negligence', generally meaning indifference. Such indifference is central in Pogge's scenarios 3 and 5, as we will see.

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[337] Ibid

[338] Ruggie's definition of complicity does not include the requirement of benefit, as Aquina's definition of 'taking part' does. Nevertheless, Ruggie's definition is still helpful to clarify the term, and its meaning in contemporary public international law and human rights parlance. I am here by and large adopting Ruggie's definition of complicity, but I am highlighting Aquinas' insight on the 'taking part' and sharing in the benefits resulting from the injustice, since this clarifies the moral issue at stake. (See Doc.UN.A/HRC/8/5, para.73-74).

[339] *ST* ii-ii, q62, a7

Four out of nine Thomistic scenarios do not justify restitution, namely *advice*, *keeping dumb*, *flattery*, and *not revealing*. Two of these factors correlate with some of Pogge's scenarios. As I shall discuss below, *keeping dumb* corresponds to Pogge's scenario 4, where the injustice is 'legally prohibited but barely deterred, [as] enforcement is lax and penalties are mild'[340]. And *advice* corresponds to Pogge's scenario 6, where the problem is 'self-caused'[341], and as such can at best justify on others a duty to provide *advice*, but cannot justify on others a duty to remediate the situation.

Aquinas's justifications for restitution by and large corroborate Pogge's justifications for a duty to remediate similar types of unjust situations, where the same premises for justice are equally at stake in Aquinas's and Pogge's discussions. The precise point at which Aquinas's framework contradicts Pogge's framework, however, relates mainly to scenarios 3 and 5, particularly because of the Aquinas's treatment of restitution of benefits unjustly received. This changes the moral stringency of my proposed scenario 5, and ranks it higher.

In my reformulation of Pogge's six scenarios below, I question Pogge's framework in relation to his claim that there is a progression from his scenario 1 to 6 in relation to their moral stringency. In my reformulation of Pogge's six scenarios, I will critically assess his original framework, and complement it with Aquinas' causation factors. This will prove to be illuminating, particularly in those scenarios where injustices are less obviously apparent *prima facie*, such as those of scenarios 3 and 5, which turn out to be the most crucial scenarios for my discussion of the GHC.

[340] Pogge, 2004, p.156

[341] Ibid, p.157

3.3.3. Reformulation of Pogge's six scenarios

This section is devoted to the critical assessment of each of Pogge's six original scenarios. Aquinas' nine causation factors will ground this engagement, and will justify my proposition of a new and different structure to Pogge's original model, as described above. I will start with the scenarios that are least controversial, and thus are easier to navigate. I will first discuss scenarios 1 and 2, which show examples where the remedial duty of the state is clear. Then I proceed to scenarios 4 and 6, which show examples where the remedial duty of justice to others clearly does not apply. Finally, I will discuss the most complex scenarios, 3 and 5.

Scenario 1 – Officially commanding the injustice M

In scenario 1, the medical condition, as Pogge puts it, is '*officially mandated*, paradigmatically by the law'[342]. Under the circumstances described in scenario 1, the law (i.e. the state, through its legislative power) directly inflicts the wrongdoing/harm, either through a legal requirement or a legal restriction. Accordingly, in my proposed scenario 1, the law directly inflicts the medical condition M by, for example, forcibly forbidding the individual producer of M' to sell M' to a certain population that is currently affected by M, with no further justifying reason. Scenario 1 narrates an obviously unjust discrimination that is not contentious: the injustice of this unreasonable discriminatory legislation is evident, and thus the justification for the duty to remediate said injustice is also evident. The moral stringency of scenario 1 is therefore obvious. It is also obvious that the

[342] Ibid, p.156

remedial duty here falls primarily on said state and arises from its legally mandating the particular injustice.

Scenario 2 – Consenting the lack of access to affordable M'

In scenario 2, the medical condition is not explicitly inflicted nor officially mandated by the law, but rather, as Pogge explains it, it is *authorized by the law*: it is a '*legally authorized* conduct of private subjects'[343], where the seller is legally authorized to refuse to sell his product to certain group of people. This description permits two different situations.

Firstly, it seems that what Pogge has in mind is a situation in which the law permits a course of action that will deprive some people of a medical treatment. The example that comes to mind here is a law that allows pharmacies to not sell a certain vaccine M' to people from a particular ethnicity, for instance. If it turns out that pharmacies would like to act on that legal permission, and decide not sell the vaccine M' to that specific group of people, and, as a result, those people cannot access the vaccine M' and end up contracting M, then a remedial duty arises. This duty to remediate the situation falls not only on the state (i.e. emerging from its legislative power in passing the unjust law), but also on other actors who have allowed this situation to develop. Thus the remedial duty could fall onto private actors as well: imagine a chain of pharmacies allowing its employees to discriminate in the way just described, by not selling the vaccine M' to people from a particular ethnicity. If, as a result, people from that ethnicity contract the

[343] Ibid.

illness M, then a moral duty to remediate arises for all those who authorized this particular discrimination.

However, Pogge's description of scenario 2 actually, allows for another possible situation, in which the law that authorizes the individual producer of M' to deny the provision of his medical services M' for any poor patient who does not have the means to pay for M'. This situation raises a different question to the one described above: here the law authorizes the limitation of access to M' only to those able to pay for M'. I will focus on this question, since it adds an element to Pogge's analysis. To be clear, I am not at this point objecting to Pogge's framework, but merely complementing it, by adding to his original scenarios some questions that are relevant to the GHC.

In this second possible interpretation of scenario 2, the law that authorizes the producer of M' to deny the provision of M' to any poor patient who does not have the means to pay for M'. Indeed, this is in actuality a basic and legitimate provision of private law: if the consumer does not pay the seller for the service or product that he provides, in principle, the seller is not legally obliged to provide it for the consumer. On the one hand, the patient (i.e. consumer of M') could allege that the individual producer/seller of M' has exacerbated his medical condition M by deteriorating his illness; on the other hand, the producer/seller of M' can legitimately allege that he is legally authorized to deny access to M', as the patient/consumer refuses to pay what he is legally liable to pay for M'. The producer/seller's conduct is legally permitted, and the patient could not, in principle, claim liability for the exacerbation of his medical condition M.

Now, under certain circumstances, this second type of situation derived from scenario 2 can give rise to claims of remedial justice and thus to remedial duty. These

circumstances are relevant in the context of the GHC. As discussed in the introduction of this thesis, one component of the GHC is the lack of access to affordable medicines. The problem of non-affordability of essential medicines is mainly a problem of domestic distributive justice and, as such, the remedial duty falls primarily on the state's shoulders. Again, this is not a matter of great controversy: when, for example, access to health care, goods and services is a constitutional right within a certain jurisdiction, the patient/consumer could arguably claim health care provision against the state.

Here, in scenario 2, the patient supposedly has the duty to pay for M', and therefore the moral stringency of scenario 2 is weaker than that of scenario 1: the moral responsibility of the state for the provision of M' is weaker (if at all existent) than in scenario 1. According to Pogge's argument, the moral weight of both scenarios 1 and 2 is supposedly very heavy, because, for Pogge, the ill health condition in both scenarios has been directly *caused* by the state's conduct: the state has enacted the legislation that is materially *connected* and that *contributes* to the exacerbation of M, either via an official mandate (scenario 1), or via a legal authorization (scenario 2). Supposedly, then, the state is the agent who bears the duty to remediate the unjust exacerbation of M, by providing M'. Although it is clear why Pogge says that scenario 2 is less morally stringent than scenario 1 (mandating and authorizing have clearly different moral forces), it is not clear why scenario 2 would be more morally stringent than scenarios 3 or 5, as I will discuss below.

Scenario 4 – Keeping dumb: individual negligence

In scenario 4, the medical condition 'arises from a private conduct that is *legally prohibited but barely deterred*'[344]. For example, there is a law that formally regulates the clinical trials for M' in country A. This specific legislation prohibits clinical trials from beubg conducted without the patient's fully informed consent, which requires, for instance, not only that the informed consent document be signed, but also that a detailed verbal explanation of all experiments and their further implications be carefully and meticulously given by the responsible medical doctor to the patient. Although this law is legitimately valid in country A, it is nonetheless ineffective: the legal requirements are a sheer formality, being completely neglected in reality by both patients and doctors. Patients typically just sign the informed consent documentation hastily and carelessly, without full awareness of the clinical trial and its possible outcomes. The doctors, for their part, do not bother to take the necessary time to adequately explain the medical procedures and their implications to the patients. At best, doctors would simply read the informed consent document aloud very quickly -- if they do that at all. To make things worse, this careless conduct, from patients and doctors alike, is socially tolerated, being thus '*barely deterred'* (to use Pogge's phraeseology). *In sum*, the infringement of the clinical trial legislation is, in my hypothetical case, socially tolerated, because 'enforcement is lax, and penalties are mild'[345] (as Pogge describes it in his scenario 4).

In this case, therefore, M is exacerbated as a malign effect of two combined negligent individual lines of conduct, from two different negligent individuals: M is caused not only by (i) the patients' lack of proper care and due diligence, entailing avoidable misunderstandings and confusions in relation to how they should have behaved during

[344] Ibid.

[345] Ibid.

such experiments, but also by (ii) the doctors' careless and imprudent conducts while conducting the clinical trials. M, therefore, comes a result of the carelessness and the lack of due diligence of both patients and doctors: M would not have been exacerbated in the way it did, (i) had the patients been careful enough to be fully aware of how to conduct themselves during the clinical trial, and (ii) had the doctors been diligent enough in their duty to fully and accurately inform their patients.

Negligence, therefore, in general terms, means carelessness, lack of due diligence, disdain, and indifference. In legal terms, however, negligence is a more technical and precisely defined concept that that sets the minimum legal standards of reasonable care and due diligence that agents are legally obliged to observe when acting and interacting. In law, a negligent conduct therefore arises when there is a duty of care, demanding a certain level of due diligence, and this duty is in some way breached: the duty-bearer not only flaunted disdain or indifference, but above all he fails in his duty of care which he was legally obliged to perform. In this thesis, I will refer to 'negligence' in its general terms, as a synonym of indifference. In this scenario, the infliction of M falls on the doctor's and the patient's shoulders, because they are directly related to the problem: their own negligent conducts feature carelessness and lack of due diligence, and leads to the undesired and unintended exacerbation of M.

The relevant difference between the sorts of negligence in my proposed scenarios 3 and 4 therefore lies precisely in the fact that, in my scenario 4, individual agents are careless, insofar as they individually act recklessly by choosing an imprudent attitude, whereas in scenario 3, the state and its institutions are careless, as the undesired and unintended exacerbation of M among the poor is a foreseeable and avoidable outcome of a specific institutional policy. When we compare the cases of individual/personal carelessness

(scenario 4), on the one hand, and institutional carelessness (scenario 3), on the other, it is easy to assume that the duties to remediate are more stringent in 3 than 4, *ceteris paribus,* as in scenario 4 the regulatory authority have made an effort to at least spell out some regulation. Considering, however, that the undesired and unintended exacerbation of M is equal in both scenarios 3 and 4, situation 3, where a political or legal institution is negligent, inflates moral culpability relative to situation 4, where the same outcome arises from individual/personal reckless conducts. I will return to this point, emerging from the difference between individual/personal conduct and institutional policies and its implication for the responsibilities that each state of affairs, shortly. Firstly, however, it necessary to observe that remedial duties (i.e. GCJ duties to restitute) do not apply in scenario 4, because the problem (the undesired and unintended exacerbation of M) is purely a result of individual conducts and personal choices, rather than a result of global institutions' conducts and policies. This same conclusion will be reached in the case of scenario 6.

Scenario 6 – Advice for self-inflicted ill health

In scenario 6, the medical condition 'arises from social institutions *avoidably leaving unmitigated the effects of a self-caused defect'.*[346] Here, the medical condition is 'self-caused', meaning a consequence of a personal behavior (i.e. bad personal choice and preference). It is therefore a self-inflicted disease, such as type 2 *diabetes mellitus* that is caused by an excessive consumption of sugar, or associated with excess body weight and lack of exercise. Whilst type 2 *diabetes mellitus* is certainly a natural defect, it is not reducible to a natural defect: personal choices and preferences contribute substantially

[346] Ibid.

to its causation. Type 2 *diabetes mellitus*, for the purpose of my hypothesis here, is a self-caused disease, and as such it falls under the category of one's personal responsibility for oneself. It follows, therefore, that because the diabetic person D in my example here has autonomously chosen to consume massive quantities of sugar and preferred to live a sedentary life (thereby embarking on a reckless course of action), that in principle and all other things being equal, the responsibility that others have to treat her type 2 *diabetes mellitus* is much less morally stringent than they would have to treat other diseases, even if the further consequences of this type 2 *diabetes mellitus* become tragically serious.

In scenario 6, just as in scenario 4, remedial duties (i.e. GCJ duties to restitute) do not apply, because the problem (the undesired and unintended exacerbation of M) is purely a result of individual conduct and personal choices,[347] rather than a result of global institutions' conducts and policies.

Scenario 3 – Not preventing, sheltering, and being complicit about the injustice M: institutional negligence

In scenario 3, 'social institutions *foreseeably and avoidably engender* (without legally mandating or authorizing)'[348] the medical condition M, by institutionally stimulating a certain conduct or policy. Here, for example, a legal act raises the taxes upon individual producers of M'. As an indirect effect, the price of M' increases considerably, and, as a further consequence, the lower social classes cannot afford M' any longer. Supposedly,

[347] *ST* ii-ii, q59, a3, ad2.

[348] Pogge, 2004, p.156

it can be argued that these lower social classes had their 'right' to have a secured access to M' violated by this institutional reform, since this violation is a secondary or indirect effect of the government's new tax policy. The harmful results imposed upon these lower social classes are secondary or indirect because they were not the primary or directly intended outcome of the tax reform: the new tax policy aimed chiefly at increasing the public budget, and these harmful results imposed upon the poorest have come about as a malign side-effect[349] of the tax regime reform.

As discussed in section 3.3.2., scenario 3 encompasses Aquinas' ideas of 'not preventing', 'sheltering', and 'taking part' in an injustice. Let us now see how they apply to the example above.

According to scenario 3's narrative, the secondary and indirect malign effects of the tax reform are undesired and unintended; yet these were foreseeable and thus avoidable side-effects of the institutional reform. They were foreseeable in as much as it should not come as a surprise that a tax increase will immediately affect the price of the taxed product. Because these malign side-effects were foreseeable, then, they could have been avoided through certain prophylactic conduct or policy decisions, such as a special governmental purchase of bulk amounts of M' at a lower price, or special subsidies for the purchase M' for the poor, for instance. If the undesired and unintended side-effects of this institutional conduct are foreseeable and avoidable, this institutional conduct can be called 'negligent', i.e. indifferent, as discussed in scenario 4 above.

[349] Side-effects are 'effects which one is not trying/intending to bring about' (Finnis, 1997, p.236).

Aquinas would identify this specific situation of indifference here in scenario 3 as 'not preventing', because the authorities, namely the institutions that had the duty to prevent the situation, did not prevent it, but rather remained indifferent to it. According to Aquinas's causation theory, this would be a strong enough justification for a duty to remediate (or offer 'restitution', as he calls it). Aquinas illustrates the situation of 'not preventing' with the example of the landowner's servants (or, as he calls them, 'officers') who have a duty of care for the land, and who receive a salary for performing such duty. As Aquinas puts it: 'when one is bound to do so [i.e. to take care of a certain land], and this applies to those officers who are charged with maintaining justice in the land; if they fail in this duty, to which a salary is appointed, and thieves increase and prosper, they are bound to restitution'[350]. In Aquinas' example, the indifference of the duty-bearers leads him to *not preventing* an injustice which was under his control and responsibility; and because the duty-bearer had not only the means but also the duty to look after that situation diligently, his lack of care (i.e. indifference) justifies now his duty to remediate the injustice to which his conducts have contributed. This, moreover, is precisely what the law would define as a negligent conduct: Tony Honore conceptualizes a negligent conduct as follows: 'the offender need not have deliberately flouted the prohibition. It is sufficient that he behaved in a way that displayed too much self-regard and too little concern for the interest of others. Indifference or unconcern, falling short of defiance, is enough'[351].

It follows, therefore, that the state, as the regulatory authority, is the agent primarily responsible here, because it is through its negligent conduct that the harm came about:

[350] *ST* ii-ii, q62, a7

[351] Honore, 'The Morality of Tort Law – Questions and Answers', in Owen, 1997, p.86

the state (through its regulatory agencies) has thus the primary duty to remediate the malign side-effects of its tax reform (put forth by its legislative power). The state could have done so through certain remedial policies (such as bulk buying or subsidies, as mentioned above). But rather, on top of being negligent and *not preventing* the harm, the state has also *sheltered* (i.e. upheld) the tax institutional reform, and *taken part* in the wrongdoing, by being *complicit* with said reform, and by beneficiating from the increased public budget.

In addition to indifference and failure to prevent wrongdoing, an agent can be remedially responsible for such wrongdoing by becoming complicit in its perpetration. This is what Aquinas calls '*sheltering*' an injustice. For Aquinas, one *shelters* an injustice, when one protects the doers of an injustice, supporting and stimulating its wrongdoings as an accomplice[352]. The question that follows is: who bears the responsibility to restitute, as a consequence of sheltering and being complicit with the wrongdoing? And the answer is: whoever has been an accomplice. As discussed in section 3.3.1., in public international law, the canonical understanding of 'complicity' is 'providing practical assistance or encouragement that has a substantial effect on the commission of a wrongdoing'[353]. So, whoever has provided practical assistance or encouragement has contributed to the injustice and has the duty to remediate it. This could equally apply to the state that has stimulated the harm through its tax reform, as in the example, but it could also apply to non-state players, for example those private parties such as lobbying groups, who have campaigned for the new regulation that causes the harm. As a result, in this case, both

[352] *ST* ii-ii, q62, a7

[353] Doc.UN.A/HRC/8/5, para.74

state and non-state actors who have supported and stimulated the institutional reform will bear remedial duties.

Finally, there is a third reason why remedial duties arise in scenario 3. This is what Aquinas calls *taking part* in a wrongdoing. For Aquinas, one *takes part* when one is not only 'an accomplice in the wrongdoing', but also 'shares in the villainy and the spoils' resulting from it[354]. In other words, besides being actively complicit in the wrong doing, another way in which one can more passively partake of an injustice is by receiving benefits from the injustice. This could happen even when the person that receives the benefits is in good faith, i.e., she does not know that these benefits derive from an illegitimate action. Then, the person has a remedial duty of justice to restitute the benefits unjustly received, until the limit of such benefit. This duty to restitute is therefore grounded first and foremost by the fact that the person has unjustly benefited from a situation, rather than on the persons' contribution to the outcome. Restitution here is thus justified by the unjust benefit, independent of her active contribution to the situation. The moral principle behind the duty to remediate in this case is therefore victim-centric: the victim of an injustice is entitled restitution because she was made worse-off, and those who have benefited from the injustice are bound to restitute the victim because the benefits would not exist had the victim not had her situation worsened-off.

So, who has, in scenario 3, the responsibility to restitute these unjust benefits derived from the new tax regime? The state has this responsibility, if it has benefited from the situation that gives raise to those unjust benefits. In the example above, the state obtains extra taxes revenue from the new tax scheme, and thus the state bear remedial

[354] *ST* ii-ii, q62, a7

duty towards those who might be made worse-off. Additionally, any non-state actors who are also benefiting somehow from the unjust scheme, share in this remedial duty.

In sum, scenario 3 establishes that remedial duties can fall on state and non-state actors alike, and can be justified by three causal factors: 'not preventing', 'sheltering', and 'taking part', as Aquinas names them. How would each of these three causal factors apply to the GHC? The GHC, as defined in the introduction of the thesis, is an undesired and unintended side-effect of the TRIPs regime. The TRIPs regime, in turn, came about as a result of a long period of negotiations among all WTO member-states, from 1986 to 1994, known as WTO's Uruguay Round. In the first instance, then, the remedial duty for 'not preventing' the undesired and unintended side-effects of the TRIPs regime fall on all WTO member-states that have been involved in the negotiation and formulation of the TRIPs and that had the authority to regulate and prevent those undesired and unintended side-effects of the TRIPs Agreement. Besides member-states, other authorities have also been negligent about the malign effects of the TRIPs: certain international organizations, such as the WTO itself, in addition to the WIPO, the WHO, and the UN, were negligent insofar as they could have made greater efforts to avoid those malign effects, but did not raise sufficient concerns regarding the potential catastrophes that the new intellectual property regime could provoke in the area of public health[355].

[355] One indication that these concerns were later taken into more serious consideration is the Doha Declaration on the TRIPs Agreement and Public Health, adopted in 2001, which reaffirms the flexibilities on intellectual property rights contained in the TRIPs Agreement, and the relevance of those flexibilities to guarantee better access to essential medicines. The 2001 Declarations therefore reaffirms:

> 1. We recognize the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics.
> 2. We stress the need for the WTO TRIPs Agreement to be part of the wider national and international action to address these problems.
> 3. We recognize that intellectual property protection is important for the development of new medicines. We also recognize the concerns about its effects on prices.

Secondly, the remedial duty for 'sheltering' falls on all global players that uphold the TRIPs regime, and are thereby complicit in its malign effects over the global poor. Both state and non-state actors 'shelter' (i.e. support and stimulate) the TRIPs regime, and thus bear remedial duties for its malign side-effects. As a result, not only those states that, as members of the WTO, were negotiating the new intellectual property regime at the Uruguay Round and pushing developing countries to adopt its globally enforceable standards of intellectual property protection as soon as possible are held remedially responsible. Private actors, such as interest and lobbying groups (in particular the pharmaceuticals and the agricultural chemical sectors), have also highly pressurized for the negotiations and adoption of the TRIPs regulations, in accordance with to their own private interests. As such, non-state actors share in the remedial duties for the damaging side-effects of the TRIPs over the global poor. In short, all global players upholding the current TRIPs regime bear remedial duty for being complicit with the malign effects of the TRIPs upon the global poor.

> 4. We agree that the TRIPs Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPs Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all.
> In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPs Agreement, which provide flexibility for this purpose'. (WTO.Doc.WT/MIN(01)/DEC/1, Doha Declaration on the TRIPs Agreement and Public Health, 14Nov2001, para.1-4)

Although the Doha Declaration reinforces the legitimacy of the limitations on intellectual property rights that the TRIPs established, encouraging their use specially for the protection of public health interests, the effectiveness of such declaration has been contested, as the implementation of those flexibilities are not easily applied in the reality of international affairs. See chapter 4 for the discussion on the existing mechanisms setting limitations and flexibilities on intellectual property rights for the sake of public health.

Third, the remedial duty for 'taking part' falls on all the global players which have hitherto been benefiting from the TRIPs regime. It falls, therefore, not only with those WTO member-states that enacted the TRIPs Agreement, but also devolves onto interest groups that were lobbying in its favor, because they have all somehow benefited by the current TRIPs regime. The remedial duty for 'taking part' is relatively straightforward: all global players that have benefited or are currently benefiting from the TRIPs regime, *ipso facto* at the expense of the global poor (by adding intellectual property-related obstacles against the advancements in their public health needs), bear remedial duties.

Scenario 5 – Institutional Negligence and Neglected Diseases

In scenario 5, the medical condition M 'arises from social institutions *avoidably leaving unmitigated the effects of a natural defect'* that is treatable and avoidable: these social institutions could have mitigated the effects of M by providing access to M'; nevertheless, those suffering from M 'avoidably lack access to the treatment that would correct their handicap'[356]. According to Pogge's original framework, the injustice of scenario 5 is quite feeble, although it is not exactly clear why.

Pogge explains in his original scenario 5 that the medical condition is a '*natural defect'*, and that it 'arises from social institutions *avoidably leaving unmitigated*' its effects'[357]. There are two distinctive features of this scenario: firstly, Pogge's scenario 5 deals with a medical condition that is a natural defect; secondly, it seems that the medical condition arises from an institutional negligence: if M could have been avoided, but was left

[356] Pogge, 2004, p.156

[357] Ibid.

unmitigated by social institutions, there is in scenario 5, just as there was in scenario 3, an institutional negligence. In this case, M seems to be here in scenario 5, just as it was in scenario 3, institutionally induced. However, Pogge's description of his scenario 5 leads to the question of how can M be a *natural* defect, being therefore naturally caused, and yet also be institutionally induced. To explain this apparent paradox, we need to differentiate institutionally induced and non-institutionally induced diseases: this distinction is morally key, because principles of justice apply to the former but not to the latter.

I assume that Pogge is in his scenario 5 talking only about those natural defects that are purely naturally caused (i.e. caused by brute bad luck), and thus are not institutionally induced, falling therefore outside the scope of justice. I assume this because Pogge later in the essay says: 'social institutions can be said to contribute substantially to medical conditions if and only if they contribute to their genesis through Scenarios 1-3'[358]. Based on this assertion, it seems that, when Pogge draws a line between his scenarios 1-3 and his scenarios 4-6, he intends to draw attention to an additional and relevant factor. By drawing this line, Pogge suggests that social institutions contribute for the infliction of medical conditions exclusively in his scenarios 1, 2 and 3 (i.e. only his scenarios 1, 2, and 3 display institutionally induced diseases), and therefore only his scenarios 1, 2, and 3 ground claims of justice.

By establishing this firm line, it seems that Pogge intends to exclude from his theory of justice those non-institutionally induced diseases that do not justify claims of remedial justice on others, such as the cases where a medical condition is an outcome of

[358] Ibid, p.158

individual negligence (his scenario 4), brute bad luck (his scenario 5), and bad personal choices (his scenario 6). Pogge, however, does not spell out these three categories of non-institutionally caused diseases *per se*, but the descriptions that he provides of his scenarios admit these interpretations.

As a matter of fact, any ill health -- institutionally inflicted or not – fundamentally has an identifiable 'natural' cause: all diseases are ultimately a natural defect of the functioning of the organic human body. Based on this fact, we can presuppose that while some natural defects are institutionally inflicted, others are not; and each category will ground, as we will see, different moral claims, with different ethical stringency.

There are two kinds of non-institutionally caused diseases: the pure naturally caused and the self-caused diseases, and both fall outside of the sphere of remedial justice (i.e. 'restitution', as Aquinas would call it). If a disease is purely naturally caused, it is a pure natural outcome of brute bad luck, and cannot properly be conceived as an injustice. Moreover, if a disease is self-caused, it is an outcome of bad choices or of personal preferences, and therefore is also not an injustice (as I have discussed in scenario 6). Neither brute bad luck, nor bad choices/personal preferences can justify remedial duties of justice on others, although other non-remedial duties of justice, or duties of benevolence may still apply[359].

Let us take the example of a purely naturally caused disease: C is a 5-year-old child and a victim of a terrible misfortune; C has developed a serious and painful brain cancer. This heartbreaking situation cannot ground remedial justice claims of restitution, but it

[359] The differences between duties of justice and reasons for benevolence are discussed in greater detail in chapter 5.

does certainly ground reasons for benevolence, and it may even ground certain non-remedial duties of justice in relation to this case as well (such as duties of distributive justice, in the case the state has here a duty to distribute certain health care, service or facility to C, given her great need, for example). I have arrived at the same conclusion when I discussed D's Type 2 *diabetes mellitus*, in scenario 6. While C's cancer is a pure naturally-inflicted disease, D's diabetes is a self-inflicted disease inasmuch as it is associated with her bad choices or of personal preferences. Yet in both cases institutions play no role in causing or negatively impacting on the disease, in a way that justifies a remedial duty.

In Pogge's original description of scenario 5, it appears that the medical condition narrates a situation in which the disease is naturally-inflicted, and thus falls outside of the scope of remedial justice. Supposedly, this is why Pogge's scenario 5 is ranked so low on his scale. However, I believe that scenario 5 captures more than this type of situation as just described. Other situations captured by scenario 5 are the following:

Suppose that M is not an ordinary example of a disease caused by a natural defect alone: M in my scenario 5 is thus different from pure naturally caused diseases, having institutional causes in addition to its natural causes. The distinctive complexity of M in scenario 5 is that M is a natural defect that has also been institutionally exacerbated; and this distinctive complexity of M also explains its distinctive moral value. As it follows, M (in my scenario 5), and C's cancer, or D's diabetes, are not on a moral par: M justifies moral duties that are more stringent than those that C's or D's diseases would justify, *ceteris paribus*. M in my scenario 5 has a different moral stringency because this natural

defect has it natural malign effects exacerbated by institutional factors, such as those having a negative impact on global poverty, like the TRIPs for example[360].

The fact that M has both natural and institutional causes may *prima facie* appear contradictory: one may think that if a disease is naturally inflicted, it is an outcome of brute bad luck alone, rather than an outcome of institutional conducts and policies. Nevertheless, these are not incompatible features. On the contrary, they can be combined, and produce catastrophic effects: certain institutional conducts and policies make the natural malign effect of diseases afflicting the poor even worse. It is in this sense that global institutions worse off the global poor: they make global poverty even worse. Global institutions can therefore contribute to further deteriorate certain diseases that afflict mainly poor (i.e. neglected diseases), by impoverishing their minimal conditions for subsistence[361]. This is precisely the case of the GHC, where global institutions – such as the TRIPs – exacerbate neglected diseases' natural malign effects, by making it more difficult for developing countries to achieve better standards of health.

But what makes a severe neglected disease any different from C's cancer or D's diabetes, which equally entail imminence of death, intense pain, severe suffering, and disability? In other words, why should natural defects that are institutionally induced be unjust, and those defects that are non-institutionally caused (cases of pure naturally-

[360] For the discussion on how the TRIPs has worsened off the global poor, see the introduction of the thesis, as well as chapters 2 and 5. For the relation between global economic institutions and global poverty, see Miller, 2007, p.184; Pogge, 2002, p.72.

[361] Obviously, it is not easy at all, in the context of global poverty, clearly to draw the line between pure naturally-caused and self-inflicted illnesses, on the one side, and institutionally inflicted illnesses, on the other. In the complex reality of severe deprivation these boundaries are all blurred, and various difficult issues are concomitantly at stake, making practical decisions really complicated. Nevertheless, the fact that the practical challenges make this moral distinction difficult, if not impossible, does not entail that it is useless.

inflicted diseases and self-inflicted diseases) not be considered unjust? Because in the former there are global institutions making things worse, and thus these global institutions have a remedial duty towards those they make worse-off without reasonable justification (i.e. the global poor). The same conditions do not apply to the latter: global institutions play no role in C's cancer or D's diabetes, and therefore no remedial duties of GCJ are justified.

In view of all that, who has, in the proposed scenario 5, the duty to remediate the global poor for the exacerbation of the natural malign effects of the neglected diseases affecting them? If we accept the factual premises presented in the introduction of this thesis, showing how the malign effects related to neglected diseases have become, since the introduction of the TRIPs in 1994, as exacerbated and catastrophic as they are today, then there is a remedial duty of GCJ that would apply to all global players upholding the TRIPs regime, as discussed under this scenario 5. Yet, if this is so, what is the difference between scenarios 5 and 3 (where global players are held responsible precisely for upholding global institutions from which they benefit)? My point here has been precisely to demonstrate that scenario 5 is different from Pogge's original conception and can, therefore, ground remedial duties of justice upon global players, precisely because scenario 5 slides into scenario 3 in morally significant ways, therefore justifying remedial duties.

In sum, I have critically assessed each of Pogge's six original scenarios, by adding considerations from Aquinas' nine causation factors. My aim was to show other complexities that Pogge's original scenarios could not capture, and thereby show how much complexity the GHC spurs. The main differences between my proposed framework, and Pogge's original model relates to scenarios 3 and 5. In scenario 3, I

have introduced Aquinas' idea of the restitution of unjust benefits, which Pogge does not consider. I have thereby expanded the complexity of the original scenario 3. In scenario 5, by turn, I have added the question of neglected diseases which can generate a more complete picture of certain scenario 5 cases, but which has not been directly considered by Pogge *per se*. I have thus built onto Pogge's original scenario 5, adding further considerations that can justify remedial duties under that scenario as well. The upshot of my scenarios is a more complete picture of the different ways in which remedial duty for the GHC can arise, and devolve onto different global players, state and non-state actors alike.

The scenarios have therefore differentiated the circumstances in which different global actors (state and non-state actors alike) bear certain remedial duties of justice (my proposed scenarios 1, 2, 3, and 5), and where they do not (scenario 4 and 6). This discussion attempted to further explain and argue in favor of the cosmopolitan view of public international law, according to which all global players, including state and non-state actors, have global justice responsibilities. My proposed scenarios have been grounded on what I called GCJ principles, regulating the reciprocal relations and responsibilities between global players individually considered, and justifying remedial duties falling on these global players individually considered, for the sake of the global common good.

Conclusion

In this chapter I have challenged the conventional state-centered approach to public international law, and have argued in favor of the cosmopolitan approach, which is a more complete, accurate and morally sophisticated account, and thus more appropriate

means of addressing the current complex problems of public international law, such as the GHC. The central aim of this chapter was to show that states are not the exclusive subjects of international law and the only bearers of human rights and global justice responsibilities. In arguing in favor of the cosmopolitan approach to public international law, chapter 3 has shown that (i) both state and non-state actors alike share in the duty to remediate the GHC (as defined in chapter 2), and that (ii) this duty is owed by all global players to the global poor (i.e. non-citizens, strangers, outsiders living in remote areas of poor countries). Chapter 3 reaches these conclusions on the shared responsibilities of all global players, by arguing against the conventional approach to public international law that supports the necessarily priority that states should grant to their own citizens over and above non-citizens.

I have first discussed Miller's theory of justice, which endorses and persuasively explains the conventional state-centered approach. Miller gives a clear explanation of why states have a human right responsibility to prioritize citizens over non-citizens. Miller's theory is particularly relevant for the purpose of this thesis, because he argues for the conventional approach of public international law, by arguing for the priority of human rights responsibilities for citizens over and above humanitarian aid responsibilities to remediate global poverty. Since the GHC is an outcome of global poverty (see, in this respect, the introduction of this thesis), Miller's theory has thus proved to be particularly illuminating for the purposes of this thesis. In section 3.1, I have pointed out some deficiencies in Miller's theory regarding the necessary priority of citizens, by introducing Eleftheriadis' arguments against the priority of citizens. Section 3.1 has therefore ventured some of the deficiencies in the conventional approach to public international law in addressing current global problems, particularly in defining the remedial duties with respect to the GHC.

In section 3.2, I have discussed Pogge's theory of global justice, which elucidates the cosmopolitan approach to public international law. Pogge builds on Miller's state-centered ideas, and adds the role of non-state actors. Pogge accepts that states bear responsibilities for their own citizens, but challenges the necessary priority of citizens by exploring six different scenarios that show the different degrees of moral responsibilities that different agents bear to a certain public health problem. In doing so, Pogge puts forth his cosmopolitan theory of justice, according to which all global players (state and non-state actors alike) bear certain responsibilities for the global poor.

I have followed Pogge's premises, by adopting his general framework of six scenarios. Nevertheless, in section 3.3, I have reformulated Pogge's six original scenarios to better tailor them to the particular context of the GHC. The upshot of my re-interpreted scenarios was showing how state and non-state global players alike are institutionally connected to the global poor and ill, and thus why all global players bear certain duties of justice (not only benevolence) to remediate the GHC, or, more precisely, have duties to GCJ.

The central concern of this thesis is the discussion of the remedial duties that different global players bear in connection to the GHC. This duty to remediate the GHC was established in chapter 2, and it was the aim of this chapter to further specify this duty, by identifying the agents of justice (i.e. duty-bearers) in relation to the GHC. Chapter 3, then, has established the premise that all global players (state and non-state agents alike) bear certain human rights and global justice responsibility in relation to this common global problem called the GHC, and the next chapter 4 will focus on one specific non-state agent, which is particularly relevant for the remediation of the GHC,

namely pharmaceutical firms. So, *in nuce*, chapter 2 established the duty to remediate the GHC; chapter 3 then examined the bearers of this duty, arguing that all global players share certain responsibilities of justice to remediate the GHC. Chapter 3 achieves this goal by raising questions about institutional connections and the relevance of these institutional connections for establishing who bears remedial duties for the GHC, and whether there are priorities towards national citizens in the fulfillment of those responsibilities. In arguing for the shared remedial duties that all global players bear for the GHC, chapter 3 has put significant emphasis on the remedial duties that wealthy states and their wealthy citizens have. The next chapter focuses on another global player who plays a crucial role in the remediation of this crisis: pharmaceutical firms.

Chapter 4 – Pharmaceutical Corporations as agents of justice

In chapter 3, I discussed the responsibilities that both states and non-state global actors (wealthy states and their wealthy citizens in particular) have in relation to the global poor (non-citizens living in remote poor countries) in one specific circumstance of global poverty, namely the GHC (as defined in the introduction to this thesis). Here, I will look at one specific type of non-state actor, namely pharmaceutical corporations, and I will explore whether there are certain responsibilities attributable specifically to pharmaceutical corporations, in relation to the GHC. I argue that in the context of the GHC, pharmaceutical companies have the responsibility to disclose some of their medical patents, when those life-saving patents are vital to remediate the crisis (and thus to discharge the global duty to remediate the crisis, as I argued in chapter 2).

This responsibility applies specifically to pharmaceutical corporations, as I argue, *not* solely because these corporations are institutionally connected to the global poor, and benefit from the current global economic scheme, which we all (as global players) currently support. As discussed in chapter 3, the fact that we all uphold global institutions, and that we all benefit from the current global economic scheme, explains why we all share, to a certain degree, certain responsibilities for the global poor and ill (namely the responsibility to respect the poor's right to health, encompassing, as explained in chapter 2, the duty not to violate the right to health, and the duty to remediate its violation, such as in the context of GHC). Nor does this specific responsibility apply to pharmaceutical firms solely because these transnational corporations are wealthy legal persons, with plenty of resources and capacity to help. Their affluence does not make pharmaceutical companies responsible for the global poor in any specific way, in comparison to other affluent global players, such as wealthy

states and wealthy natural persons: pharmaceutical firms, as wealthy non-state actors, are responsible in the same way as any other wealthy global players, but not in a special way. We all share, as global players, a certain degree of responsibility for the global poor, but each of us bears different forms of responsibility, depending on our relation to the problem of global poverty.

It is my aim in this chapter to argue that there are certain responsibilities of justice that apply specifically to pharmaceutical corporations as such - as owners of a certain special type of property that is vital to remediate the GHC, namely, medical patents. First, this remedial duty is justified precisely by reference to the limitations of private property rights, as I will discuss below. So, by exploring these limitations, this chapter will clarify this responsibility. This duty to disclose certain patents for the specific purpose of the GHC is first and foremost a duty arising from the possession of a particular form of private property. Secondly, this responsibility to remediate the GHC is justified by the institutional connections among all global players, and precisely by the fact that global players benefit from the global institutional order. The responsibility to remediate the GHC is shared among all global players, and allows the imposition of proportionate duties on different actors to provide efficacious remedies for the GHC[362]. As I shall discuss below, the duty to disclose certain patents would be not only efficacious, but also proportionate: the current global economic order under the TRIPs regime allows pharmaceutical companies to profit greatly from patents in developed countries. So it seems fair and proportionate that they contribute to remediate a common problem, at least up to the occurrence of those benefits they have derived from the global economic order, by releasing certain patents that are vital to solve the problem.

[362]Chapter 5 provides a framework with the main institutional remedies that exist or that are under consideration to tackle the different malign consequences of the GHC.

One objection that pharmaceutical companies could make against having to release patents because of a public need is based on the legitimate exclusivity of pharmaceutical corporations' intellectual property rights over their medical patents. The legitimacy of pharmaceutical corporations' private ownership over their medical patents would override any duty to release those medical patents into the public domain.

It is mostly agreed that the right to private property may, in certain circumstances, have limitations. The extent of such limitations is debatable and varies according to the different schools of thought regarding private property: libertarians will admit limitations to private rights only in very rare circumstances; others will accept limitations of private property in a greater number of cases. The basic agreement, nevertheless, is that some sort of minimal limitation is justifiable. In this chapter I will discuss different representative accounts of the various theories of private property. I will argue that under all of them, the right to private property that pharmaceutical corporations have over their medical patents may be limited under the circumstances of the GHC, and to the extent that this limitation is necessary for helping to substantially remediate this crisis. Furthermore, I will show that the existing legal exceptions of intellectual property rights are already based on these moral limitations.

In the following sections, I will discuss three theories of private property: Thomas Aquinas', John Locke's and Robert Nozick's. Aquinas' view is relevant because his theory is unique in taking the needs of the poor into serious consideration; indeed, it gives them a form of preeminence. In this sense, it is a useful point of reference when discussing practical limitations of private property for the sake of the global poor. Locke's theory is central as it is arguably the most fundamental and influential theory of private

property in modernity, having shaped much of our current understanding of private property. Finally, I will discuss Nozick's view of private property, because his libertarian perspective is the most challenging to my argument on a limitation of pharmaceutical companies' patent rights.

4.1. Aquinas, commutative justice, and private property

Aquinas builds on the Aristotelian[363] concept of property, defining property as things (*res*) that are in principle public: they at first pertain to the common good, as they are commonly owned by the whole of humanity. These public resources (including natural resources and capital goods) are then made private: their possession is privately maintained, and regulated by law[364]. Accordingly, property law regulates these resources that are subject to ownership (*dominium*)[365]. The exclusive dominium that certain individuals or groups have over certain resources is justified as mutually beneficial: first, the exclusivity is justified by the fact that a common resource administered by many tends to be neglected, disused, or inefficiently managed, and, secondly, the exclusivity is justified as it gives the private owner an incentive to foster his own productivity, creativity, and inventiveness, in a way that he can develop his private property to its full

[363] Aristotle writes: 'Property ought to be common in a sense, but private speaking generally . . . it is better for possessions to be privately owned, but to make them common in use; and to train citizens to this is the special task of the legislator' (*Politics*, II, 2.1263a26).

[364] As Aquinas puts it: 'Community of goods is ascribed to the natural law, not that the natural law dictates that all things should be possessed in common and that nothing should be possessed as one's own: but because the division of possessions is not according to the natural law, but rather arose from human agreement which belongs to positive law, as stated above (*ST* ii-ii, q57, a2, ad3). Hence the ownership of possessions is not contrary to the natural law, but an addition thereto devised by human reason' (*ST* ii-ii, q66, a2).

[365] See Finnis, 1998, p.188

potential[366]. Thus, for Aquinas, the regulation of resources by property law is beneficial to the whole community: private ownership of resources must always serve the good of the community, and it is the role of property law to guarantee the just use of private properties so that the common good is served. Property rights exist mainly therefore to regulate adequately private ownership by ensuring incentive-based advantages to the owner in harmony with the common good, and as a just compensation or payment for the owner's labor and productivity[367]. Since property rights are a means of achieving the common good of the whole community, property rights serve thereby the purposes of commutative justice[368].

Aquinas divides one's private ownership into two groups: the *propium* and the *superfluum*. The *propium* includes those resources one needs to survive and to fulfill one's various personal commitments, including one's responsibility to support one's dependents, one's household and one's own businesses. *Superflua* are the leftovers: it compounds one's *residuum*, i.e. the excessive resources, which go beyond the *propium*

[366] Aquinas, Locke and Nozick agree on the same reasons justifying private property and its mutual benefits for society. See Aquinas, *ST* ii-ii, q66,a2; Locke, *Two Treatises of Government – Book I*, para.86; Nozick, *Anarchy, State and Utopia*, 1974, p.177

[367] 'I answer that two things are competent to man in respect of exterior things. One is the power to procure and dispense them, and in this regard it is lawful for man to possess property. Moreover this is necessary to human life for three reasons. First because every man is more careful to procure what is for himself alone than that which is common to many or to all: since each one would shirk the labor and leave to another that which concerns the community, as happens where there is a great number of servants. Secondly, because human affairs are conducted in more orderly fashion if each man is charged with taking care of some particular thing himself, whereas there would be confusion if everyone had to look after any one thing indeterminately. Thirdly, because a more peaceful state is ensured to man if each one is contented with his own. Hence it is to be observed that quarrels arise more frequently where there is no division of the things possessed'. (*ST* ii-ii, q66,a2)

[368] For the definition of commutative justice, see chapter 3.

and are thus dispensable. This is a relevant divide, as it tracks the rationale behind the limitations of private property[369].

Property rights entitle the right-holder to exclude others from access to his private resources. Nevertheless, this exclusion is not absolute. As Finnis has said in his own articulation of the Thomistic theory of property, '[t]he private owner of a natural resource or capital good has a duty of justice to put it to productive use, or if he lacks the further resources required to do so, to dispose of it to someone willing and able to do so'[370]. Justice therefore requires that the thing owned be put into productive use and not be wasted. Therefore, a limitation on the property right's exclusivity is the necessary condition of 'economically productive development or use'[371] of the thing owned. If the private owner does not comply with this requirement of justice, there will be an unjust situation. The situation is unjust because private property is justified precisely because of its ability to incentivize the productive use of goods. Consequently, if those goods are undeveloped, unused, and thus wasted, the purpose of making such goods private is defeated, and thus it would make sense to make them part of the common stock once again. If the owner retains an undeveloped, unused, and thus wasted property for himself, he is unjustly keeping a property that, as a matter of justice, is not his anymore: the property now is part of the common stock.

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[369] In his comments to Aquinas' *ST,* ii-ii, q32,a6c, Germain Grisez explains that the divide between *superfluum* and *propium* is elastic: 'what one needs to live decently and meet one's responsibilities [i.e. *propium*] is not rigidly fixed but somewhat elastic . . . the limit defining the superfluous remains elastic, and allows what is reasonably considered necessary at one moment to become available the next to meet someone's unanticipated need'. (Grisez, *The Way to the Lord Jesus,* 1993, 2.10.E.2c)

See also Finnis, 1998, pp.191-195

[370] Finnis, 1980, p.172

[371] Ibid

For Aquinas justice demands that *superflua* be disposed for the common benefit of the poor.[372] This assertion may sound too demanding, and too difficult to implement: to require that the whole *superflua* of one's wealth be distributed to the poor may sound at first unreasonable and unworkable. A clarification is thus key to further understand this specific duty of justice towards the poor. The duties justified by the idea of *superflua* have a crucial characteristic: they are duties of justice, rather than actions of supererogation[373]. The duties related to the *superflua* are a matter of justice, and shall not be misunderstood as supererogatory donations[374]. This is a common misinterpretation because when one thinks of duties to make one's resources and wealth available to the poor, the temptation is to think about supererogation. But supererogation goes beyond justice; it goes beyond the call of duty. Supererogatory actions are voluntary altruistic gifts, and, as such, by definition, cannot be enforced. On the other hand, duties of justice can be made enforceable through law, and such enforceability is justifiable as a way of giving to one what is his due[375]. Justice does not require, nonetheless, that one's resources needed for investing and fulfilling one's personal commitments and responsibilities for one's businesses are handed over to the poor. This would be considered a benevolent donation of one's *propium*, and thus an act of supererogation. On the contrary, what justice requires is that wealthy people dispose their excessive wealth – their leftovers, their *residuum* – to the poor, but only after all

[372] *ST* ii-ii, q.66

[373] See chapter 5 for this distinction.

[374] Grisez, 1993, 2.10.D.1d; 2.10.E.1a, 2c, 5b; Finnis, 1998, p.192

[375] This does not imply that duties of justice always need to be enforced by the law, since sometimes a full enforcement of justice through law could be counterproductive, or simply impossible. For example, it would be unreasonable and too intrusive if the state attempts to know exactly how much *superflua* each person has. This would be a form of violation of privacy, and a great potential for the state's abuse of power; furthermore, this would probably fail to produce a perfect distribution of *superfluous* goods — either because of inefficiency, or because such an intrusive state could, among other things, nullify the government opposition and then privilege unchecked government elites.

their personal responsibilities and individual commitments to themselves, their family, their friends, and their business enterprises are completely fulfilled. For, 'resources needed for the investment and other expenses reasonably arising in one's legitimate business enterprises are not *superflua*'.[376]

4.2. Locke and the labor theory of private property

John Locke is commonly known as the father of both private property and intellectual property doctrines. Locke justifies private property as a compensation for the owner's labor and as an incentive for his productivity. Locke's labor theory of property explains how private property is acquired: since men have a right to the means necessary to preserve their lives, men may legitimately acquire as private property those natural resources with which they mix their labor. That is to say, when people mix their labor with natural resources or lands, an originally public and common property becomes private[377]. Nevertheless, the appropriation of property by labor is not absolute: it is constrained by the needs of other men. Locke, in this respect, talks about three limitations on private property: the so-called spoilation proviso, the sufficiency proviso, and what I will call 'the duty to others' proviso. These three provisos originate from Aquinas' idea of *superflua*[378]*.* Locke builds on Aquinas' idea, and further elaborates on it, by breaking Aquinas' original idea of *superflua* into these three interrelated provisos.

[376] *ST* ii-ii, q32,a6c; *ST* ii-ii, q117,a3 ad2, a4ad; Finnis, 1998, p.194.

[377] Locke, *Two Treatises of Government – Book II*, paragraph 27

[378] Waldron, 'Enough and as Good Left for Others'*,* in *The Philosophical Quarterly*, 29:117, October 1979, 319-328, p.327

The spoilation proviso has the purpose of limiting the appropriations of resources that will 'perish uselessly in [the appropriator's] hands'[379]. The spoilation proviso therefore aims at preventing unnecessary waste caused by the negligence of the owner: since natural resources exist for human use, and shall not be left unused until it spoils, it is not permissible that the owner does not put his private property to use. If the owner does not use his private property, and also denies other men use of it, the legitimacy of his appropriation by his labor is lost, and the resource becomes public again[380].

The sufficiency proviso sets a further limitation on private property: a private appropriation can only be legitimate 'at least where there is enough, and as good left in common for others'[381]. The sufficiency proviso is justified by the need to regulate acquisition regarding those more complicated situations of scarcity, where there is not enough left in common for others.[382] Under these circumstances of deprivation, a private property becomes public again in the name of the common good.

Finally, there is a third limitation on private property, which I call 'the duty to others' proviso. As Locke puts it, a poor person under dire circumstances has 'a title to so much out of another's plenty, as will keep him from extreme want, where he has no means to subsist otherwise'[383]. The third limitation on private property therefore sets a stringent

[379] Locke, *Two Treatises of Government – Book II*, para.46

[380] See Waldron, *God, Locke, and Equality – Christian Foundations in Locke's Political Thought*, 2002, p. 171.

[381] Locke, *Two Treatises of Government – Book II*, para.27

[382] Waldron himself explains it: 'I believe . . . that is better understood as a *sufficient* condition . . . highlighting the point that there is certainly no difficulty with unilateral acquisition (which satisfies the other provisos) in the circumstances of plenty, but leaving open the possibility that some other basis might have to be found to regulate acquisition in circumstances of scarcity'. (2002, p.172)

[383] Locke, *Two Treatises of Government – Book I*, paragraph 42

duty on those who have a superabundance of resources: the wealthy are required to aid the poor, when they are under circumstances where they cannot satisfy their own basic human needs[384]. This is a duty imposed on the wealthy for the direct benefit of the poor.

In summary, both Aquinas and Locke agree that private property is not only legitimate, but also desirable. It is an institution that serves not only as a remedy against men's tendency to negligence, but also as an incentive to foster men's productivity, creativity, and inventiveness, allowing humans to work on and develop their private properties to their full potential[385]. Nevertheless, both philosophers set limitations on this private right: private property is legitimate as long as it serves the common good. In certain circumstances, particularly when there are some in need and others who possess in excess, private property loses its private character, and becomes public.

Both Aquinas and Locke agree that the general idea of *superflua* can ground limitations on private property in the name of the common good. Building on the Natural Law tradition, Locke further elaborates on Aquinas' original idea of *superflua*, by adding three provisos that provide more specific conditions for limitations of private property. So, while Aquinas' more fundamental idea of *superflua* draws a general distinction between the *propium* and the *residuum/superfluum*, Locke's idea sets more specified provisos, emphasizing, in particular, the need to prevent unnecessary waste and negligence, and the need to leave some property for the dispossessed, in addition to the need to dispose to the poor what is excessive. The influence of Aquinas' original idea of *superflua* is clear especially in relation to the third proviso.

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[384] Waldron, 1979, p.328

[385] *ST* ii-ii, q66,a2; Locke, *Two Treatises of Government – Book I*, para.86

To add further detail, Aquinas makes a general distinction between what is necessary to live a decent life and perform one's occupation (*propium*) and what is non-necessary (*superfluum*). This divide justifies certain limitations on private property rights, and the duty to dispose of what is excessive (*and* thus not necessary to fulfill one's decent standard of living and one's chosen occupation) for the benefit of the poor. Locke accepts that this general idea of *superflua* justifies certain limitations on private property rights, but he emphasizes the duty to put the property into productive use, and the duty not to waste its potential. Locke's idea derives from, and, in this sense, is part of, Aquinas' original concept. Aquinas would certainly agree with Locke's emphasis on an 'economically productive development or use'[386] of the property. The difference is that Aquinas emphasizes the duty to dispose of what is superfluous (i.e. things not needed) for others who may need them.[387] Locke, on the other hand, while also accepting this duty in his third proviso, emphasizes the duty to put into productive use what is superfluous (i.e. things not needed and not used). Nevertheless, because the precise differences between both philosophers on their own formulations of *superflua* do not matter much for the purpose of this thesis, it suffices to say that both Aquinas and Locke would justify certain limitations of private property based on the general idea of *superflua*, i.e. what is superfluous, unnecessary, and excessive.

[386] Finnis, 1980, p.172

[387] Gilson comments on *ST* ii-ii, q66,a2 as follows: 'That each should possess as his own what is necessary for his own use is quite sound and safeguard against want and neglect. But it is a very different matter when some accumulate more goods than they can use under the title of private property. To assume ownership of what we do not need is to make fundamentally common goods our own. The use of such goods should remain common. The remedy for this abuse is never to consider the goods possessed in our own name as reserved for our own use. Let us have them, since they are ours, but let us always keep them at the disposal of those who may need them. The rich man who does not distribute his superfluous wealth is robbing the needy of the goods whose use is theirs by right. He is defrauding them by violence. Wealth, let us recall, is not bad in itself. But we must know how to use it reasonably.' (Gilson, *The Christian Philosophy of St. Thomas Aquinas*, 1961, p.315)

4.3. Nozick and the entitlement theory of justice

Robert Nozick's theory of justice is central to my discussion because his libertarian account is the most challenging to our view that pharmaceutical corporations have certain responsibilities of justice for the global poor, in the context of the GHC. It is worth clarifying that, although Nozick's idea was not conceived as a theory of global justice -- rather as a theory of (domestic) justice within his so-called 'Minimal State' -- his account of private property applies to the discussion on the limits of private property generally, and therefore also at the global level. Interestingly, as I will show later in this chapter, even under Nozick's view, which is considered the most favorable to the exclusivity of private rights, pharmaceutical corporations would have limitations regarding private property and certain responsibilities regarding their medical patents under the pressing circumstances of the GHC.

Nozick's theory of justice begins with the premise of a free society, based on the free will of all individuals, who interact with one another, through voluntary exchanges of holdings or entitlements in a free market. Nozick talks about 'the justice in holdings', or, as he names it 'the entitlement theory of justice', based on principles that apply to three basic situations: (i) justice in acquisition of holdings; (ii) justice in transfer of holdings; and (iii) rectification of injustices, namely the violation of any of the first two principles.

The first principle of justice defines when a person legitimately acquires an entitlement to a certain holding: a person appropriates an unowned holding (resources, such as

property, goods, or money)[388] justly if this is an original appropriation. This follows from the Lockean idea that an individual can justly appropriate a non-owned resource by mixing his labor with the resource, and as far as there is 'enough and as good left' in common for others (the 'Lockean proviso' as Nozick calls it, or what we term 'the second proviso', discussed above). Nozick's argument for the acquisition of unowned holdings is the following: being the owner of myself, and thus of my own labor, if I mix my labor with an unowned resource, I become the owner of such resource, and in acquiring the ownership of such resource, I will be allowed to transfer such ownership if I so wish[389].

The second principle of justice addresses the transfers of holdings or entitlements from one individual to another, subsequent to the original acquisitions of those holdings or entitlements. As Nozick defines private transactions, they take the general form of either *voluntary exchanges* or *gifts*[390]*.* Therefore, a person can justly acquire a holding originally entitled to another, and become entitled to it either through a just voluntary exchange with the previous owner, or by receiving it as a gift from him. The previous owner was entitled to the holding until that time, and after the transfer the recipient becomes legitimately entitled to the holding. In the context of free societies and free markets, Nozick's second principle ensures 'justice-preservation'[391] and entails

[388] Singer cites these three as examples of holdings when discussing Nozick's theory ('The right to be rich and poor', in *The New York Review of Books*, March 6, 1975, p.4).

[389] Nozick, 1974, pp.174-8

[390] Ibid, p.150

Nozick seems to acknowledge the general difference between justice and charity (or 'philanthropy', as he names it), although he seems to include both concepts under the same category of 'voluntary exchanges'. As Nozick defines it, 'voluntary exchanges' comprise both those commercial transactions that can be regulated by private law, and those charitable donations that he refers as 'gifts' and that cannot, by definition, be enforced by the law.

[391] 'A distribution is just if it arises from another just distribution by legitimate means . . . The means of transition from one situation to another specified by the principle of justice in transfer are justice-preserving,

'mutually-agreed-to exchanges whereby people choose to give to others what they are entitled to give or hold'. As he puts it: 'people are choosing to make exchanges with other people and to transfer entitlements, with no restrictions on their freedom to trade with any other party at any mutually acceptable ratio . . . People transfer their holdings or labor in free markets, with the exchange ratio (prices) determined in the usual manner'[392], where 'the usual manner' is the invisible hand of the open markets[393]. Nozick also adds that a voluntary exchange will be 'productive' when it is mutually beneficial: both buyer and seller are made better off by their transaction than they were before their private dealing. As Nozick puts it: in productive voluntary exchanges, 'both parties do benefit in the sense of being the recipients of productive activities. Where one of the parties does not so benefit and is unproductively "served", it is fair that he merely barely compensates the other.'[394]

The third principle of the entitlement theory is the principle of rectification of an injustice, and it comes into play when any of the two first principles are violated, and thus there is an infliction of harm. That is to say, when one acquires or transfers a holding without having the entitlement to do so (which could only be conferred to him by one of the two first principles of justice), he acquires or transfers such a holding illegitimately and unjustly. The principle of rectification of injustices in holdings serves then the purpose of restituting justice and preserving the foundations of a free society and a free market, by avoiding the infliction of harm to one another in the community. The third principle of

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and any situation actually arising from repeated transitions in accordance with the principle from a just situation is itself just' (Nozick, 1974, p.151).

[392] Ibid, pp.186-7

[393] Ibid.

[394] Ibid, p.86

justice therefore spots unjust situations, such as those where 'some people steal from others, or defraud them, or enslave them, seizing their product and preventing them from living as they choose, or forcibly exclude others from competing in exchanges'[395]. Then, because none of these situations are legitimate and permissible forms of acquiring and transferring, the third principle of justice asks: 'what obligations do the performers of injustice have toward those whose position is worse than it would have been had the injustice not been done? Or than it would have been had compensation been paid promptly?'[396]

Harm avoidance is key to both the restitution and the preservation of justice in any free society and free market. For Nozick, the critical issue of the Lockean proviso is whether an appropriation or a transfer of a holding worsens the situation of others[397]. Aditionally, as Nozick explains:

> [s]omeone may be made worse off by another's appropriation in two ways: first, by losing the opportunity to improve his situation by a particular appropriation or any one; and second, by no longer being able to use freely (without appropriation) what he previously could. A *stringent* requirement that another not be made worse off by an appropriation would exclude the first way if nothing else

[395] Ibid, p.152

[396] Ibid

[397] This is also the crucial point in the Lockean theory of property. As Nozick explains the Lockean theory and proviso: '[t]he crucial point is whether appropriation of an unowned object worsens the situation of others. Locke's proviso that there be "enough and as good left in common for others" (sect. 27) is meant to ensure that the situation of others are not worsened (if this proviso is met is there any motivation for his further condition of nonwaste?)' (1974, pp.175-6).

> counterbalances the diminution in opportunity, as well as the second. A *weaker* requirement would exclude the second way, though not the first.[398]

Nozick makes this distinction between a 'stringent' and a 'weaker' application of the Lockean proviso to explain that his theory incorporates the idea in its weaker form. He writes:

> I assume that any adequate theory of justice in acquisition will contain a proviso similar to the weaker of the ones we have attributed to Locke. A process normally giving rise to a permanent bequeathable property right in a previously unowned thing will not do so if the position of others no longer at liberty to use the thing is thereby worsened. It is important to specify *this* particular mode of worsening the situation of others, for the proviso does not encompass other modes. It does not include the worsening due to more limited opportunities to appropriate.[399]

Harm or injustice, as Nozick argues, does not take place when one person worsens the situation of another by merely limiting his opportunities to appropriate or transfer, or when one seller appropriates the resources to make a good that another is selling, entering then into fair competition with him[400]. In other words, harm or injustice takes place, and thus grounds harm compensation or injustice rectification, only when someone is worse off through the violation of his individual rights.

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[398] Ibid, p.176

[399] Ibid, p.178

[400] Ibid

Nozick defines his theory of justice in holdings as a theory of distributive justice that informs the *distribution* of holdings based on the criterion of equality of freedom, rather than equality of opportunity or resources. He discusses three possible circumstances where entitlements can be distributed justly among members of his so-called 'Minimal State', and he stresses that his use of the term 'distributive justice' is a 'neutral'[401], rather than a 'patterned'[402] use, as he does not engage with the question of how to *re*distribute certain holdings such as opportunities or resources. In fact, he argues that enforcing such redistribution under the claims of fairness (based on equality of opportunity and resources) is actually contrary to justice, except if it is to justify a taking as a rectification of a past harm[403]. As he puts it, '[f]rom the point of view of an entitlement theory, redistribution is a serious matter indeed, involving, as it does, the violation of people's rights. (An exception is those takings that fall under the principle of the rectification of injustices.)'[404]

As mentioned above, a key idea in Nozick's theory of justice derives from the Lockean proviso that there must be 'enough and as good left in common for others', in order to guarantee just acquisitions and transfers where others are not worsened or harmed[405]. In Nozick's theory, the Lockean proviso serves the sole purpose of avoiding injustice and harm, rather than supporting egalitarian claims on opportunities and resources[406].

[401] Ibid, p.150

[402] Ibid, p.157

[403] Ibid, 1974, p.90

[404] Ibid, p.168

[405] Ibid, p.175

[406] Ibid, p.178

Hence, the Lockean proviso in Nozick's theory will serve to spot injustices that occurred during the original appropriation or subsequent transfers, and then justify a rectification of said injustice through a limitation of the ownership. As he puts it: 'Once it is known that someone's ownership runs afoul of the Lockean proviso, there are stringent limits on what he may do with (what it is difficult any longer unreservedly to call) "his property"'[407]. So, although for Nozick individual rights are very strong, private property can justifiably be limited if – and only if – the Lockean proviso is violated[408]. And, 'the question of the Lockean proviso being violated arises only in the case of catastrophe'[409]. Nozick engages with two specific examples to illustrate the sort of catastrophe that can justify these strict limitations on private property rights[410].

The first example of catastrophe is the example of a waterhole in the desert. The appropriation of the sole waterhole in a desert is illegitimate. According to Nozick's theory, clearly, this is an illegitimate original acquisition, because it violates the Lockean

[407] Ibid, p.180

[408] Ibid, p.178

[409] Ibid, p.181

[410] It is worth clarifying that Nozick generally conceptualizes rights as side-constraints, so that, in general terms, 'the rights of others determine the constraints upon your actions' (p.29). As he puts it: 'The side-constraints view forbids you to violate these moral constraints in the pursuit of your goals' (p. 29). Therefore, generally speaking, side-constraints, and thus individual rights, are pretty much absolute. The obvious question is whether there are exceptional circumstances when it is justified to violate a right. This is a general question, for which Nozick provides a general answer: 'The question of whether these side constraints are absolute, or whether they may be violated in order to avoid catastrophic moral horror, and if the latter, what the resulting structure might look like, is one I hope *largely* to avoid' (emphasis added) (p. 30).

Nozick wants to avoid answering this general question, because he wants to avoid making a general statement about the absoluteness of any individual rights and their potential limitations in the face of a catastrophe. But this does not mean that he cannot deal with the more specific question of whether a particular right, such as the right to private property, could be limited for the sake of avoiding a moral catastrophe in particular circumstances. And indeed he deals later in his book with the question of the limitation of private property rights by certain catastrophes (pp.180-1). I discuss this particular limitation below.

proviso: being the one and only waterhole in that desert, its private ownership is forbidden, because it would otherwise not leave 'enough and as good left in common for others'[411]. A slightly different circumstance in the same example, where the proviso is equally violated, states the following: suppose that there are several waterholes in the desert, and all dry up, except yours. In this case, your original acquisition is legitimate, and you have full property rights over your waterhole up to that point. However, due to an unfortunate change in the ordinary circumstances, your property rights will suffer a limitation: you will no longer be allowed to charge as much as you wish for the water supply. As Nozick emphasizes, the owner does not lose his property rights: the waterhole is still his private property; yet, his individual rights 'are overridden to avoid some catastrophe'[412]. So, for Nozick, when a piece of private property has been legitimately appropriated, there can only be a limitation of the proprietor's private property rights if those limitations are necessary 'to avoid some catastrophe'[413]. This catastrophe -- i.e. 'this unfortunate circumstance, admittedly no fault of his' -- provides a justification to invoke the Lockean proviso[414], and thus a justification to limit some of the owner's private property rights. In other words, a catastrophe is a legitimate reason for limiting individual rights in the name of public interests; it would impose on the private owner the duty to release some of his private property to the public use.

The second example of a set of circumstances which can justify limitations on private property rights involves a medical researcher. The medical researcher 'finds a new

[411] Ibid, p.180

[412] Ibid

[413] Ibid

[414] 'This unfortunate circumstance, admittedly no fault of his, brings into operation the Lockean proviso and limits his property.' (Ibid)

substance in an out-of-the-way place. He discovers that it effectively treats a certain disease and appropriates the total supply.'[415] Here, Nozick also provides an example of someone who monopolizes the total supply of something that is crucial for others to survive, and as such can also entail a potential catastrophe. Yet, different from the first example of the waterhole in the desert, where others were deprived of the thing essential for their survival (i.e. water), here, the medical researcher appropriates the total supply of the substance, but he does not deprive others of it. Whereas in the first example the unfortunate circumstance worsens the situation of others in such a catastrophic way that it justifies the limitation of certain private property rights, here, in the second example, the medical researcher does not worsen the situation of others:

> He does not worsen the situation of others; if he did not stumble upon the substance no one else would have, and the others would remain without it. However, as time passes, the likelihood increases that others would have come across the substance; upon this fact might be based a limit to his property in the substance so that others are not below their baseline positions; for example, its bequest might be limited. The theme of someone worsening another's situations by depriving him of something he otherwise would possess may also illuminate the example of patents. An inventor's patent does not deprive others of an object which would not exist if not for the inventor. Yet, patents would have this effect on others who independently invent the object. Therefore, these independent inventors, upon whom the burden of proving independent discovery may rest, should not be excluded from utilizing their own invention as they wish (including selling it to others) […] Yet we may assume that in the absence of the original

[415] Ibid, p.181

> invention, sometime later someone else would have come up with it. This suggests placing a time limit on patents, as a rough rule of thumb to approximate how long it would have taken, in the absence of knowledge of the invention, for independent discovery.[416]

So, for Nozick, the medical researcher is not worsening the situation of others in general, because the he is not depriving them of the substance he appropriated by mixing his labor with it. (Quite the contrary, the medical researcher is actually improving their situation, as the invention would not exist but for his mixing his labor with the substance.) Therefore there is no violation of the Lockean proviso here, because the substance can still be found abundantly in nature, and thus others can still have access to and appropriate it.

Yet, although the medical researcher is not worsening the situations of others in general, he may be worsening the situations of some specific others, namely (i) 'the independent researchers', who are deprived of their freedom to mix their own labor with the substance, to arrive at a similar invention, and, of course, (ii) those who could have benefited from the discoveries of these independent researchers. This is what justifies for Nozick a limited patent term, which expires after some time.

It is worth clarifying here that Nozick actually does not make a clear distinction between property rights and intellectual property rights. He introduces the topic of intellectual property when he explains his idea of catastrophe as a limitation of private property, and engages with the example of the medical researcher. It is also worth clarifying here that

[416] Ibid

the intellectual property regime justifies the monopoly granted by patents differently: as I will discuss below, the WTO's agreement on trade-related aspects of intellectual property rights (the TRIPs Agreement) justifies the patent term first and foremost as a compensation to the original innovator and a necessary incentive to foster future innovation, rather than primarily as a protection for the interests of 'independent inventors', as Nozick suggests. Article 33 of the TRIPs guarantees a minimum of twenty years for the patent term, and such a time limit secures the inventor's right to recoup his investments on R&D, and to receive a recompense for his labor in the form of profit. In this connection, the patent term does not exactly, as Nozick suggests, serve the purpose of setting a 'rough rule of thumb to approximate how long it would have taken, in the absence of knowledge of the invention, for independent discovery'[417]. Instead, the two reasons behind the patent are to provide an incentive for future novelties, as well as a compensation for the past efforts and labor[418]; and the twenty year patent term is an estimation of how much time would be necessary for an inventor to recoup the investments previously made[419]. This suggests that other theories of property rights might be better aligned with the purposes of the intellectual property regime. But even if this is so, Nozick's theory of private property is still relevant for our purposes specifically because pharmaceutical companies could invoke Nozick's views in defense of stronger private property rights over their medical discoveries and in advocacy for a freer global market. Yet, as I will discuss below, the GHC qualifies as a catastrophe, and thus justifies strict limitations on private property rights.

[417] Ibid

[418] Risse, 'Is There a Human Right to Essential Pharmaceuticals? The Global Common, the Intellectual Common, and the Possibility of Private Property', in Millum and Emmanuel (eds), *Global Justice and Bioethics*, 2012, p.67

[419] Hestemeyer, *Human Rights and the WTO – The Case of Patents and Access to Medicines*, 2008, p.159

4.4. Application of the theories of property rights to the case of pharmaceutical corporations and the GHC.

Intellectual property is a special kind of private property, and is the crux of the question related to pharmaceutical companies and the GHC. Both private property and intellectual property rights provide reasons for the exclusionary rights of private owners; both also provide their respective justifications for specific limitations of these exclusionary rights. Here, I will discuss the purpose of intellectual property rights and of their limitations, and then analyze how each of the three theories of private property discussed in the previous sections would apply to the specific case of pharmaceutical companies as private owners of vital medical discoveries. This is not the place to establish which theory of private property is 'the right one'. My argument avoids this vexed question by claiming that the responsibility of pharmaceutical companies argued for in this chapter would be justified under very different theories of private property, and even under the more 'libertarian' one. Here, I explore how this responsibility of pharmaceutical companies to remediate the GHC can be justified under different theories of property, by reference to the limitations of private property rights. As mentioned above, the remedial duty of pharmaceutical companies in the context of the GHC is specific: they have a duty to disclose certain patents that are vital for the remediation of the GHC and this duty arises first and foremost from their ownership of certain medical patents. Secondly, this responsibility to remediate the GHC is justified, as argued in chapter 3, by the institutional connections among all global players, and particularly by the fact that global players benefit from the global institutional order.

As discussed in chapter 3, all global players share the responsibility to remediate the GHC, and this justifies the imposition of proportionate duties on different actors to provide adequate remedies for the GHC. As I shall discuss below, when it comes to pharmaceutical firms, the remedial duty takes the form of a disclosure of certain patents relevant in the context of the GHC. This duty is justifiable (given that these specific patents are particularly relevant for the remediation of the crisis), and it is also proportionate (as it seems fair that these global players who profit so much from the TRIPs institutional arrangement now are asked to contribute to remediate a common problem arising from that arrangement).

4.4.1. Some relevant aspects of the current Intellectual Property Rights Regime

So, what are intellectual property rights? Both property rights and intellectual property rights are exclusionary rights. Property rights entitle the right holder to exclude others from access to his private resources (or into his private ownership). Such exclusion is justified as it gives the private owner the necessary incentives to develop the property owned, using his creativity and inventiveness. Such exclusion also gives the private owner the necessary security or stability to enjoy the owned property -- making the most of it, and continuing investing in it -- making use of it to the fullest extent. Likewise, intellectual property rights (a specific field of property rights) entitle the patent holder to exclude others from access to his private invention. Such exclusion is justified as it gives the private owner (patent holder) the necessary incentives to develop his idea, using his creativity and inventiveness. It is the role of intellectual property rights to guarantee the justice in the exclusivity granted by patents over technological inventions, in such a way that the incentive-based advantages to the patent owner are aligned with the common

good. In the global sphere, it is mainly the role of the WTO's TRIPs Agreement to provide such regulation.

This treaty was negotiated between 1986 and 1994[420] and introduced intellectual property rules into the global trade institutional system. In brief, the TRIPs establishes minimum standards of protection that each WTO member-state must respect within its jurisdiction and must give to the intellectual property of other WTO member-states. Nation-states are, nevertheless, allowed to use intellectual property rights exceptions, for example to remediate public health problems. In the case of trade disputes between member-states over intellectual property rights, the WTO's dispute settlement system is available[421].

It is worth clarifying here that although my argument is a purely normative one, it will be useful for our purposes to provide a brief account of the basic regulation of limitations of intellectual property under the TRIPs agreement. I will use TRIPs only as a point of reference in a normative discussion on limitations of intellectual property.

Under the TRIPs Agreement (article 28), the patent owner has the right to exclude unauthorized others from certain activities -- such as 'making, using, selling, offering to sell or importing'[422] -- concerning the patent object (which can be either a product, such as the substance of a drug component, or a process, such as a method of synthesizing a

[420] This period is known as the WTO's Uruguay Round.

[421] *Understanding the WTO: The Agreements - Intellectual property: protection and enforcement*. Available at: http://www.wto.org/english/thewto_e/whatis_e/tif_e/agrm7_e.htm

[422] Art.28.1, TRIPs

pharmaceutical product)[423]. The exclusionary rights of the patent owner last for a period of time of twenty years[424]. The right to exclude others to compete with the right holder allows the patent owner to fully enjoy the fruits of his invention: it guarantees first that all effort and labor previously invested in the invention are now paid back to the patent owner, and secondly that the patent owner is rewarded with a fair profit as an incentive for further R&D[425].

There are two main limitations to the exclusivity provided by patent rights. The first limitation is the possibility of compulsory licenses (article 30 of the TRIPs), where a WTO member-state makes an unauthorized use of a patented invention prior to the expiration of the patent term and with the payment of a fee[426] to the patent owner. Different from voluntary licenses, compulsory licenses are not previously consented by patent owner[427]. The latter are thus only justified in special cases, namely a national emergency, extreme urgency, or other relevant circumstances of public interest, including a necessity of public health (for examples, when a patented drug plays an essential role in the country's health policy, when there is an insufficient supply of the

[423] On the difference between 'product' and 'process', see Ho, 'An introduction to TRIPs', in Loyola University Chicago School of Law – *Public Law & Legal Theory Research Paper* No. 2011-021, pp.56-88, 66-7; Hestermeyer, 2008, p.64

[424] Art.33 of the TRIPs requires that the term of protection shall not end before the twenty year period, counted from the application filing date. WTO member-states are, nevertheless, allowed to provide more protection. So they can extend the patent term beyond twenty years, when appropriate.

[425] Ho, 2011, p.69; Hestermeyer, 2008, p.68, 75

[426] Art.31(h) says that the right holder has to be paid 'adequate remuneration in the circumstances of each case, taking into account the economic value of the authorization'. For further discussion on which level of remuneration would be enough, see Hestermeyer, 2008, p.248; ICTSD and UNCTAD, *Resource Book on TRIPs and Development*, 2002, pt 2.5, p.137

[427] Hestermeyer, 2008, p.239

patented medicine, or when there is the surfacing of a new disease in a country)[428]. Also, in order to be justified compulsory licenses have to meet several procedural requirements that include: the observation of 'individual merits', a justification based on the limited scope for the license, the existence of prior negotiations, and tentative efforts to previously obtain consent or authorization from the patent holder under the proposition of reasonable and fair commercial terms and conditions[429]. Compulsory licenses have also the potential benefit of significantly lowering the prices of medications, and thus improving access to such medications: by terminating the monopoly, it fosters competition and thereby reduces the prices of medicines. And indeed the mere imminent possibility of a compulsory license granting is sufficient to pressurize the patent holder to lower the prices of the patented drug[430]. Previously some countries (like South Africa, Thailand, Brazil, and most recently India) have made use of a compulsory license to guarantee the access to specific medication key to their public health policy[431].

Nevertheless, compulsory licenses are not a sustainable long-term way to secure access to medicine, since they eliminate the incentive for R&D. Although the

[428] Ibid, p.239

[429] Ibid, p.244-6

[430] Ibid, p.241

[431] A complete report on compulsory licenses has been produced by Beall and Kuhn, and they conclude thus: 'We assembled a database of all episodes in which a compulsory license was publically entertained or announced by a WTO member state since 1995. Broad searches of compulsory license activity were conducted using media, academic, and legal databases, yielding 34 potential compulsory license episodes in 26 countries. Country- and product-specific searches were used to verify government participation, resulting in a final database of 24 verified compulsory licenses in 17 nations. We coded compulsory license episodes in terms of outcome, national income, and disease group over three distinct periods of compulsory license activity. Most compulsory license episodes occurred between 2003 and 2005, involved drugs for HIV/AIDS, and occurred in upper-middle-income countries (UMICs). Aside from HIV/AIDS, few compulsory license episodes involved communicable disease, and none occurred in least-developed or low-income countries'. (Beall and Kuhn, 'Trends in Compulsory Licensing of Pharmaceuticals Since the Doha Declaration: A Database Analysis', in *PLoS Med*, 9:1, 2012, http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001154)

government owes the patent owner an adequate remuneration for the unauthorized use (article 31(h) of the TRIPs) of his creation, the fact is that the patent holder does not need to authorize the use of his patented invention: the creator is forced to accept such use, and is left with no alternative but to accept the situation and negotiate a fee for the use, where such fee is 'likely far less than what the owner would like to charge in a free market'[432].

The second form of limitation on intellectual property rights and on the exclusivity of the patent owner is broadly called 'limited exceptions to patent rights', and it is provided in article 30 of the TRIPs, which dictates: 'Members may provide limited exceptions to the exclusive rights conferred by a patent, provided that such exceptions do not unreasonably conflict with a normal exploitation of the patent and do not unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties'. The WTO Panel in 'Canada-Patent Protection of Pharmaceutical Products'[433] clarified the general provision of article 30 of the TRIPs, by discussing two specific types of exceptions provided by the Canadian Patent Act: the Bolar Exception, and the Stockpiling Exception. The Bolar Exception allows generic competitors to start taking the necessary steps in advance – that is during the patent term – so that they can obtain all the necessary regulatory approval to market their generic product right after the expiration of the patent term[434]. The Stockpiling Exception

[432] Ho, 2011, p.70.

[433] Doc.WTO:WT/DS114/R*, WTO Panel Report Canada – Patent Protection of Pharmaceutical Products*, 17March2000.

[434] When analyzing the Canadian case, the WTO Panel concluded that even though the patent holder has the right to exclude others during the patent term, in this particular case, there is no unreasonable conflict with the requirement of 'normal exploitation'. 'Normal exploitation', as the panel concluded, does not mean twenty years of absolute/*de facto* exclusivity, where any mere initiations of the regulatory approval procedure would have to strictly wait until the formal expiration date. The Panel nevertheless declared that [the patent holder has] 'no legitimate interest' in extending their monopoly period beyond the actual patent

allows generic competitors who have used the Bolar Exception to start manufacturing and stockpiling of the generic version six months before the expiration of the patent term, so that these generic competitors would be able to begin their sales immediately after the expiration of the patent term[435].

These are the examples of 'limited exceptions to patent rights' discussed by the WTO Panel. Although the Panel helped to clarify the provision of article 30 of the TRIPs by discussing these two particular examples of exceptions to intellectual property rights, the Panel did not give conclusive remarks on what the phrase 'limited exceptions' means with any great precision, and it did not clearly define the scope of all possible exceptions to intellectual property rights. As a consequence, the WTO member-states still have plenty of freedom for crafting their regulatory exceptions applicable to generic competitors, in a way that the marketing of generic versions can be facilitated and abbreviated when the public interest so requires.

If, on the one hand, WTO member-states have room to craft intellectual property rights limitations that are relevant for their domestic reality, these national regulations obviously need to conform to the basic purposes of the TRIPs agreement. The TRIPs and, thus, the intellectual property law institutions have two fundamental purposes: they provide an

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term, considering that, after the initiations of the regulatory approval procedures, there is a period until the actual entry in the market and commercialization of the generic product. Also, and most importantly, there is the 'legitimate interest' of consumers to have access to the (presumably) cheaper generic version as soon as possible, and without any undue delay after the expiration of the patent term. (See Ho, 2011, p.72; Hestermeyer, 2008, p.235)

[435] The WTO allows the stockpiling of generics if this is *limited* in quantity, time, and extension. In this particular case in Canada, the WTO Panel concluded that the stockpiling terms were not limited enough, precisely because the Canadian law allowed generic competitors to manufacture and stockpile *unlimited* quantities of their generic version. The WTO Panel considered this lack of limitation on the quantity of the generic products inappropriate, and thus unacceptable, even though the WTO Panel did not explicitly say that stockpiling of generic versions should never be permissible in any case. (See Ho, 2011, p.73; Hestermeyer, 2008, p.235)

incentive to further scientific innovation and also a compensation to recoup the costs of R&D[436]. These are the two purposes of intellectual property law and they also set the scope of intellectual property rights: intellectual property rights are a legitimate form of incentive and compensation, but both incentive and compensation need to be reasonable, fair, and just. In other words, intellectual property needs to be regulated in a way that the legislation does not exceed or go beyond the limits of these two purposes[437].

4.4.2. The moral justifications for intellectual property rights' limitations

Having the TRIPs agreement as the point of reference for our discussion, the question now is the following: to what extent is it morally justified to limit pharmaceutical companies' private property rights for the purpose of solving the GHC?

Aquinas, Locke and even Nozick agree that under certain circumstances, there is a duty of justice to make some private property available to the public. Obviously, they would explain those circumstances in very different terms, giving different reasons for private property rights exceptions: while Aquinas and Locke would agree on limitations based on the general idea of *superflua*, Nozick would justify limitations based on the idea of catastrophe. But the crucial point is that they would all agree that in certain circumstances, the private owner has the duty to disclose its private property to the public, for the benefit of the public interest. Now I will analyze how Aquinas', Locke's and Nozick's accounts justify this duty of the private owner to make his private property

[436] Risse, 2012, p.67

[437] Ibid

available to the public, and then see how their ideas apply to our specific case of concern: the duty of pharmaceutical companies, as private owners of vital medical discoveries, to make them available to the public.

4.4.2.1. Superflua as a limitation of private property

Both Aquinas and Locke explain the limitations on private property invoking the idea of *superflua*. *Superflua* are those things that are superfluous, unnecessary, and excessive. In short, *superflua* are those things that owners have, but do not need. According to natural law doctrine, they are destined to the purpose of succoring the poor. What could *superflua* possibly mean for pharmaceutical companies? To put it in another way, what are the things that pharmaceutical companies possess but that are not needed?

One example of things that pharmaceutical companies have in superabundance and have not been further used are the medical data resulting from research that did not lead to the expected results. In these cases where the research experiments do not prove to be useful for the pharmaceutical companies' goals, all the efforts put on the R&D up to that point are wasted, since the medical data related to those experiments are set aside, unused. Recently, the so-called 'Open Innovation' approach in Product Development Partnerships (PDP) have been advocating the public disclosure of those medical data, and their maintenance in public libraries, such as ChEmBL, PubChem, GSK's Tres Cantos Open Lab Foundation, WIPO Re:Search, Pfizer and Academic Centres for Therapeutic Innovation, and Eli Lilly's Open Innovation Drug Discovery[438]. In these public libraries, independent researchers have open access to pharmaceutical

[438] Sheridan, 'Industry continues dabbling with open innovation models', in *Nature Biotechnology*, 29Nov2011, pp.1063-1065.

companies' data banks, and they can continue the research experiments that seem most relevant to them. Under the 'Open Innovation' approach, these independent researchers can discover and further develop knowledge that is free to use without any legal/contractual restriction. So, if unused medical data would be lost and wasted anyway, it seems therefore reasonable to say that pharmaceutical companies should disclose this medical data to public libraries. This would make public the companies' private property (i.e. their unused medical data) under the justification of avoidance of needless waste.

Another example of *superflua* is also related to the 'use' of medical data. Article 28 of TRIPs declares the patent owner's right to exclude independent researchers from 'making, using, selling, offering to sell or importing' the patent object[439]. Recently, however, there has been a debate on a particular form of 'use', namely the 'experimental use' of a patented invention. Although the WTO Panel has not specifically considered this question, it does recognize that scientific experiments are a legitimate form of use that differs from commercial use, which is not legitimate[440]. The experimental use exception would allow scientific progress during the patent term (that is to say, despite the fact that the product or the method is patented). Moreover, 'making' and 'using' a patented invention for experimental purposes is already legitimate in various jurisdictions[441] in the name of the public interest and to foster production of scientific innovation and knowledge[442]. It also seems reasonable to argue that, at the moment the

[439] Art.28.1, TRIPs

[440] Doc.WTO:WT/DS114/R, 17March2000

[441] Germany, Argentina, and Japan are examples (Hestemeyer, 2008, p.238, n.162).

[442] The experimental use of patented inventions implies the access to the clinical data that has been submitted by the patent owner with his patent application to a government. Although Art.39(3) of the TRIPs

patented drug enters the market, the patent holder 'exhausts'[443] its patent exclusionary rights, as he obtains in exchange a continuous reward for his invention during the patent term. The exhaustion of the patent holder's exclusionary rights would then set the original clinical data free for further research purposes – although it does not liberate the clinical data for competitive exploration and commercial use, which would be an unfair competitive practice. The liberation of the original clinical data for further scientific purposes is justified by reference to the fact that after the entry of the medicine into the market the patent holder does not need data exclusivity for his research purposes any longer – he only needs the exclusivity for his commercial purposes as a way of compensation for his efforts. Although his commercial purposes are lawful and just, it would be unnecessary for achieving the purposes of patent protection (compensation for R&D and incentive) to extend the commercial exclusivity in a way that it would also

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requires the intellectual property governmental authority (responsible for approving the patent application) to protect the submitted clinical data from 'unfair commercial use' by competitors the interpretation of 'unfair commercial use' is also disputable (Correa, *Trade Related Aspects of Intellectual Property Rights: A Commentary on the TRIPs Agreement*, 2006, p.283). International trade bodies have been discussing the exact definition of 'unfair commercial use'. On the one hand, PhRMA – Pharmaceutical Research and Manufacturers of America, and some governments that support it, argue that the original clinical data together with the object of the patent itself (i.e. the patented product and/or process) must be protected from subsequent generic applicants. On the other hand, other jurisdictions allow subsequent generic applicants to have immediate access to such data. (Ho, 2011, p.76). Clearly, such interpretative debate is central to the access to medicines and access to knowledge movements, since the scope of clinical data protection will directly influence the time by which the generic version may be able to be marketed. Generic competitors in most jurisdictions benefit from an abbreviated patent application, as they are in general not required to submit detailed clinical data regarding the safety and efficiency of a patented drug. The generic applicants can usually rely on the original clinical data formerly submitted on behalf of the approved and patented drug. The generic applicants therefore usually merely submit clinical data sufficient to show the generic version's bioequivalence to the branded drug (Guimarães de Lima e Silva, 'Sham litigation in the pharmaceutical sector', in *European Competition Journal*, 2011, 7:3, Dec.2011, pp.455-503; Ho, 2011, p.76). The controversy resides precisely in whether the generic applicant's reliance on the original data previously submitted by the innovator constitutes an 'unfair commercial use' or a permissible 'scientific use'. PhRMA and USTR – the United States Trade Representatives, for instance, argue that such reliance on the original clinical data is unfair, as the generic competitor free rides on the R&D investments made by the patent holder. Others argue that such reliance by the generic competitors intrinsically serves scientific purposes, being legitimate as it is responsive to the public interest (Ho, 2011, p.77).

[443] I am using the word 'exhaustion' here in analogy with the Doctrine of Exhaustion, aka the First Sale Doctrine, which stipulates that 'where a patented product is placed on the market by the patent holder or with its consent, the patent holder has exhausted its patent rights and the buyer of the product is free to resell the product as it wishes. The doctrine balances the interests of the patent holder and those of the buyer, who obtains full property of the product' (Hestermeyer, 2008, p.230).

include research/experimental exclusivity. The type of monopoly granted by medical patents to pharmaceutical companies is therefore a commercial monopoly, rather than a scientific monopoly. So, the pharmaceutical patent is a monopoly over the medical substance and process -- i.e. the pharmaceuticals; it is not a monopoly over the medical knowledge. Therefore, if the scientific use of original clinical data is not under the patent protection, it should be disclosed to the public interest as soon as the patent is granted and the product enters the market, because from this time onward the patent owner will be rewarded by the commercialization of the patented pharmaceutical. The scientific use of the original clinical data has at this moment completely discharged all its beneficial promises to the patent holder, and then it qualifies as the patent owner's *superflua.* As such it should be set free from the patent owner's private dominium to be fostered by other researchers.

A third example of *superflua* relates to the fact that the poor nations are neglected markets. Over 80% of pharmaceutical corporations' global sales are concentrated in the USA, Canada, the EU, and Japan. As these are the markets with the highest demand for pharmaceutical products, they are also the highest-priced.[444] Indeed, these developed nations are the major source of pharmaceutical corporations' profits. Hence, because poor countries' markets lack the necessary financial capacity to buy expensive medical treatments, they are considered neglected markets. If pharmaceutical corporations make negligible profits in these neglected markets, the benefits of the intellectual property regime for pharmaceutical corporations (i.e. compensation for R&D and incentive, as explained above) are insignificant in these poor nations. Therefore, the intellectual property protections in these poor countries are not necessary from the point of view of

[444] Ibid, p.161

the pharmaceutical companies' business model. They are therefore superfluous. If medical patents are superfluous in poor countries (which coincide with those most negatively affected by the GHC) then the protection granted by the intellectual property in those countries is *superflua*.

These three possible instances of *superflua* would yield a duty of pharmaceutical companies, as private owners of vital medical discoveries, to disclose their unused scientific knowledge and patents for their use for the benefit of succoring the poor. Of course in fulfilling these duties practical implications will arise. It is the purpose of institutions to overcome these practical implications so as to allow effectively for action coordination for the sake of specifying and fulfilling these duties without affecting other relevant moral considerations[445]. In this chapter I want only to spell out the justice-based moral duties of pharmaceutical companies, founded on the requirements of justice (GCJ to be more precise). In following chapters I will address the institutional question.

4.4.2.2. Nozick's views on the limitation of private property rights: the case of catastrophes

It would seem that under Nozick's theory something like a duty of pharmaceutical corporations to succor the poor would not apply. This is because Nozick explicitly argues that there is no obligation to help the poor. Nozick declares this when he is arguing against the Welfare State, in defense of his idea of the Minimal State. For Nozick, the fact that some individuals benefit from a specific social structure or institutional

[445] One such consideration might be that disclosing information relating to research could lead to competitors using that information in the market where the company is competing and from which it is deriving profits.

arrangement is not a justification for imposing restrictions on their individual rights and freedoms. As he puts it: 'the fact that […] we benefit from current patterns and forms created […] does not create in us a general floating debt which the current society can collect and use as it will'[446].

The Nozickian strong emphasis on individual rights and freedoms would support the argument that an industrious businessman has a legitimate right to the fortune and the profit that his skills and hard labor have brought to him legitimately and justly. Milton Friedman's well-known saying summarizes this view clearly: 'the social responsibility of business is to increase its profits'. Friedman forcefully further explains it, very much in agreement with Nozick's perspective:

> In an ideal free market resting on private property, no individual can coerce any other, all cooperation is voluntary, all parties to such cooperation benefit or they need not cooperate […] Society is a collection of individuals and of the various groups they voluntarily form […] That is why in my book *Capitalism and Freedom*, I have called it [the doctrine of 'social responsibility'] a 'fundamentally subversive doctrine' in a free society, and have said that in such a society, 'there is one and only one social responsibility of business – to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the same, which is to say, engage in open and free competition without deception or fraud'.[447]

[446] Nozick, 1974, p.95

[447] Friedman, 'The Social Responsibility of Business is to Increase its Profits', in *The New York Times Magazine*, 13Sep1970.

Nozick's criticism of the welfare state in defense of his idea of the Minimal State could be applied to the global perspective. It provides a powerful argument against the strongest forms of cosmopolitan theories, such as Singer's, who argues for a universal duty to aid all the needy of the world in every way possible[448]. Nozick's reply would run as follows: the fact that we all benefit from current patterns and forms created by the global institutional order does not create in us a general floating debt which the current global order should collect and use for the benefit of the global poor. Indeed this would also be an argument against the key cosmopolitan thought that multinational corporations have responsibilities for global poverty, mainly because they benefit from the global institutional arrangement and its various global economic institutions. Cosmopolitans (like Pogge, for instance), as I have discussed in chapter 3, argue that pharmaceutical companies have responsibilities for the global poor and ill, and such responsibilities are justified by the global institutional connections between these multinational corporations and the global poor. For Pogge, pharmaceutical corporations are institutionally connected to the global poor and ill, and benefit from this institutional arrangement, and thus bear a special role in the cause of universal access to essential medicines.

4.4.2.3. The case of catastrophes

It is still possible to argue that even Nozick's theory would require that pharmaceutical companies have a duty to disclose the relevant patents in relation to the GHC, in the way defended here, based on Nozick's idea of the licit limitation of private property for the purpose of avoiding a catastrophe.

[448] Singer, 1972

For Nozick, only under the circumstances of a catastrophe, can private property rights be limited, and the private owner has a duty of justice to make his private property available to the public. As he puts it: 'the rights [of owners] are overridden to avoid some catastrophe. (Overridden rights do not disappear; they leave a trace of a sort absent in the cases under discussion.)'[449]

But what is a catastrophe? Nozick does not provide a precise outline of the concept of a catastrophe, which suggests that for his theory 'catastrophe' is not a term of art but rather should be taken as having its common meaning. We could say that devastating natural disasters, such as earthquakes, are catastrophes. The 2011 earthquake tsunami in Japan that caused 15,883 deaths is then an obvious example of a catastrophe. Others may add that human-inflicted disasters can be equally dreadful, and thus are also examples of catastrophes. Take the 1986 Chernobyl nuclear accident, for instance. While the number of deaths is small ('only' 31 deaths are directly attributed to the accident – including all the reactor staff and emergency workers, and 'only' 64 deaths from radiation are counted in official reports), the negative environmental and health impacts are awful enough to consider this accident a catastrophe. The Chernobyl accident has released radioactive material that has not only contaminated the air and the waters (including rivers, lakes, groundwater, and reservoirs that supply water to several European and Asian countries), but has also accumulated in the food chain. On top of these harmful environmental consequences, there are also negative health impacts. Thyroid cancer among children, for instance, is considered to be the main health impact arising from the Chernobyl accident (4,000 cases were reported in the official records for 2005). Radiation experts add a number of worldwide cancer deaths outside the highly

[449] Nozick, 1974, pp.180-1

contaminated zone around Chernobyl of approximately 5,000, and an extra 4,000 cancer deaths in future. One could argue that the number of deaths directly related to the accident is negligible; others could also say that the number of potential deaths related to the Chernobyl disaster is a debatable estimation. Nevertheless, the 1986 accident is commonly referred to as a catastrophe: its health impacts have spread across countries and across generations.

As the most memorable examples of catastrophes, one could cite the nuclear bombing of Hiroshima and Nagasaki, and World War II (WWII) itself. The 1945 nuclear bombing in Japan killed between 90,000 and 166,000 people in Hiroshima and between 60,000 and 80,000 in Nagasaki. Of the deaths which occurred on the day of the explosion, approximately 60% resulted from flame burns, 30% from falling debris, and 10% from other causes. During the following months, 15–20% of the deaths were caused by radiation sickness, 20–30% by burns, and 50–60% by other injuries and compounded by illness. The estimated total number of deaths (including deaths from war-related disease and famine) occurring over the four years of WWII (1941-1945) varies from 50 to 85 million, which means 12.5 to 21.25 million deaths per year.

We could roughly understand catastrophes as: natural or human-inflicted disasters that have dreadful impacts that either cause a great number of deaths, or have serious negative effects on persons and their environment, and that commonly spread across countries and generations. Is the GHC a catastrophe?

From this definition it follows that the crucial element in establishing whether a particular event qualifies as a catastrophe or not is its consequences. What are the consequences

of the GHC? Let us first analyze the figures and thereafter evaluate the impact of the crisis across countries and then across generations.

Firstly, in terms of numbers, the GHC could easily qualify as a major global disaster: its figures far surpass the number of deaths of the 2011 earthquake tsunami in Japan, the 1986 Chernobyl nuclear accident, and the 1945 nuclear bombing of Hiroshima and Nagasaki. The numbers of the GHC can actually be compared to the statistics of WWII (which resulted in between 12.5 to 21.25 million deaths per year): according to health specialists, 'the lives of some 50,000 human beings, mostly children, are cut short *every day* by avoidable poverty-related causes'[450]; these amount to between 14 and 17 million deaths *every year* from lack of sanitation and access to essential medicines[451], including 2.6 million deaths directly related to neglected diseases[452], which means that the GHC causes about 1 million times more deaths yearly than the 2011 earthquake tsunami, about 7 million times more deaths than the 1986 Chernobyl accident, and about 100 times more than the 1945 nuclear bombing of Hiroshima and Nagasaki.

Secondly, the GHC's consequences spread across countries. The WHO's diagrams make evident the epidemiological profile, and their maps show the geographical distribution of neglected diseases: these illnesses are mainly concentrated in tropical and sub-tropical areas all around the globe, but in actuality they are present on all continents: they are widespread in Africa, the Americas (mostly in Latin America and

[450] Pogge, *How to incentivize Universal Access to Advanced Essential Medicines*, p.1, http://www.economyandsociety.org/events/Pogge_background_paper1.pdf

[451] Kay and Williams, *Global Health Governance – Crisis, Institutions, and Political Economy*, 2009, p.10

[452] *Diseases of poverty remain sorely overlooked*, 14 Dec 2012, http://blogs.nature.com/news/2012/12/diseases-of-poverty-remain-sorely-overlooked.html

Caribbean regions, but also reaching the impoverished and marginalized minority populations in North America[453], Europe (both Western and Eastern)[454], Asia (particularly India and South Asia)[455], and even in the Pacific Islands and Australia (especially among their indigenous communities)[456]. Additionally, it is worth remarking that, with the increased trade, urbanization and migration flows resulting from globalization, there has also been an increase in the proliferation of diseases across all national borders[457]. The most obvious examples are neglected infectious diseases, whose viruses multiply rapidly and travel across the oceans, leading quickly to pandemics[458]. In this connection, the WHO describes how alarming a pandemic catastrophe can be: 'an outbreak or epidemic in one part of the world is only a few hours away from becoming an imminent threat elsewhere'[459]. To make things worse, the spread of both communicable and non-communicable diseases across nations also entails the spread of resistance to certain

[453] The major neglected infections of poverty, as they are called, in North America include Chagas disease, leishmaniasis, trench fever, dengue fever, toxocariasis, strongyloidiasis, ascariasis, cysticercosis, trichomoniasis, leptospirosis, toxoplasmosis, and syphilis. In this respect, see Hotez, 'Neglected Infections of Poverty in the USA', in *PLoS Neglected Tropical Diseases*, 2:6, 2008.

[454] For further details, see Hotez, 'Neglected Diseases Amid Wealth in USA and Europe', in *Health Affairs,* 28:6, 2009, pp.1920-25.

[455] See Hotez et al, 'The Neglected Tropical Diseases of India and South Asia: Review of Their Prevalence, Distribution, and Control or Elimination', in *PLoS Neglected Tropical Diseases*, 5:10, 2011.

[456] See Hotez et al, 'Neglected Tropical Diseases of Oceania: Review of Their Prevalence, Distribution, and Opportunities for Control', in *PLoS Neglected Tropical Diseases*, 7:1, 2013.

For detailed epidemiological profiles on each neglected disease by country or region, see WHO, *NTD data and maps*, http://gamapserver.who.int/mapLibrary/app/searchResults.aspx

[457] See Millum and Emanuel, 'Introduction', in *Global Justice and Bioethics*, 2012, p.4; Wolff, *The Human Right to Health,* 2012a, p.67; Wolff, 'Global Justice and Health', in Millum and Emanuel, *Global Justice and Bioethics*, 2012b, p. 91; Outterson, Pogge and Hollis, 'Combating Antibiotic Resistance Through the Health Impact Fund', in *Boston University School of Law Working Paper No. 11-30*, 21Jun2011, p.10

[458] Wolff, 2012b, p.91

[459] WHO, *World Health Report 2007 – A Safer Future: Global Public Health Security in the 21st Century, Geneva*, 2007, p.6

medication due to the irrational use or misuse of antibiotics, which exacerbates the negative impacts of these global illnesses and their urgency[460].

Third, the GHC's consequences have perpetuated over centuries, and thus have spread across various generations. Much of the neglected diseases are persistent through history: malaria was first reported by ancient Chinese medical writings of 2700BC[461]; leprosy is referred to many times in the Bible; yaws was introduced to Europe from Africa in the 15th century as a result of the slave trade; the so-called 'Old World' Diseases, such as malaria, leprosy, yaws, and tuberculosis, were brought by Europeans to their colonies in the Americas, killing millions of native Americans during the colonization period[462]. These neglected diseases have afflicted various generations persistently over the course of the centuries, and they continue to kill millions up to the present day[463]. Given the continual neglect and the hopeless prospect of future solutions, the WHO published in 2012 a strategy to accelerate scientific progress tackling neglected diseases, setting targets for the prevention, control, elimination, and eradication of particular neglected diseases until 2020[464], which was endorsed by

[460] Kay and Williams, 2009, p. 27; Outterson, Pogge, and Hollis, 2011, p.10

[461] On the history of malaria, see: http://www.cdc.gov/malaria/history/index.htm

[462] *Columbian Exchange Diseases – Latin America & the Old World*, http://suite101.com/article/columbian-exchange-diseases--latin-america--the-old-world-a241749

[463] A look at the succeeding WHO reports provides additional evidence of the persistence of these illnesses – and particularly of their neglect by public health authorities – over the last few decades. The WHO has been calling on public health authorities for action regarding neglected diseases since its founding in 1948. The list of the main reports since 1948 tackling specific health crises over the decades, and also the background history of the global impact of neglected diseases over the years can be found at WHO A66/20, *Neglected Tropical Diseases – Prevention, Control, Elimination and Eradication,* 15Mar2013.

[464] WHO/HTM/NTD/2012.1: *Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation*, Geneva, 2012

various global players – including 13 transnational pharmaceutical corporations.[465] This seems to be a renewal of the political commitments established at the beginning of this century by the Millennium Development Goals, in view of the failure of the international community to achieve its health-related targets by 2015 (the deadline fixed by the Millennium Declaration), and also in view of the discouraging prospect based on the statistics of neglected diseases amounting to the enduring 10/90 gap[466].

I have been discussing the grave negative impacts of the current GHC, and I have argued that its catastrophic magnitude can be measured by its appalling figures, and by its persistent manifestation all over the continents, and over the centuries. If a catastrophe is a disaster that has dreadful impacts causing either a great number of deaths, or serious negative consequences, we can conclude that the GHC is a catastrophe, and as such it justifies certain reasonable limitations on private property, following Nozick's line of thought.

The GHC is a catastrophe in view of the enduring lack of medical innovation (i.e. medical R&D) for neglected diseases that remains practically the same for decades with very

[465] Following the WHO's *2020 Roadmap on Neglected Tropical Diseases*, the international community – including The World Bank, non-government organizations, individual donors, endemic countries, developed countries, and 13 pharmaceutical transnational corporations *(*Abbott, AstraZeneca, Bayer, Bristol-Myers Squibb, Eisai, Gilead, GSK, Johnson & Johnson, Merck KGaA, Merck Sharp & Dohme (MSD), Novartis, Pfizer and Sanofi*),* - endorsed the *London Declaration on Neglected Tropical Diseases*, on 30 January 2012, affirming their public commitment to do their share to advance R&D through partnerships and provision of funding to find next-generation treatments. The 2012 London Declaration is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67443/NTD_20Event_20-_20London_20Declaration_20on_20NTDs.pdf

[466] The lack of scientific progress regarding neglected diseases extends over the decades. Although important scientific progress has been made – 756 new medicines have been approved between 2000 and 2011 – only 3.8% (29 medicines out of 756) are prescribed for the treatment of neglected diseases. (MSF, DNDi, *Medical Innovation for Neglected Patients – Important Progress Over the Past Ten Years, But "Fatal Imbalance" Persists,* 2012 http://doctorswithoutborders.org/events/symposiums/2012-lives-in-the-balance/assets/files/Medical-Innovations-for-Neglected-Patients.pdf)

little progress and that amounts to the maintenance of the 10/90 gap. As discussed in the introduction to this thesis, the lack of medical innovation/R&D is the core of the GHC.

Under the current regime, scientific innovation depends on intellectual property protections. That is to say medical innovation/R&D depends on medical patents. The current intellectual property regime legitimately grants the monopoly over the medical discovery to pharmaceutical corporations that have invested in the R&D of such medical knowledge. If this privately owned medical knowledge is crucial to control or even solve the existing GHC, is it legitimate to claim that these private properties should be disclosed for the benefit of the public interest?

Given that the GHC is a global catastrophe, it seems that even under Nozick's theory it would be legitimate to disclose these vital private properties to the public. As with any other reasonable limitation of individual rights, however, there needs to be clear conditions informing the public disclosure. This is already the rationale behind the existing intellectual property regime. As discussed above the TRIPs Agreement sets boundaries over the exceptions of intellectual property rights: compulsory license, Bolar Exception, and stockpiling, when granted, have to be limited in time, in scope, and in object. Hence if medical knowledge owned by pharmaceutical companies should be disclosed to remediate this particular public problem, then such disclosure ought to meet these three conditions. First, the public use of the patent should be limited in time: it is legitimate until the catastrophe is controlled or solved. Secondly, the public use should be limited in scope: discriminations between use of the patented knowledge for the populations afflicted by the GHC and the populations not affected are legitimate and crucial for the feasibility of any public health enterprise and for the economic viability of

the company and its research[467]. Thirdly, the public use should be limited in object: only those medical patents that are vital to remediate the GHC would be made public. In this vein, not everybody is entitled to have open access to all medical innovations/R&D tackling all illnesses, to produce and distribute or sell the medicine anywhere. Instead, the responsibilities of pharmaceutical companies in relation to the GHC are limited: they have a duty to publicly disclose only those medical patents that are vital to control or solve the crisis, for the period of time necessary for such control or solution, and only in relation to the afflicted populations. Again, implementing these duties is a complex task, requiring a sophisticated institutional framework. In this chapter I do not attempt to provide that framework. My aim here is to provide an account of the moral duties of justice that would justify bringing into existence those institutions and which should inform their design.

An objection that could be raised against this duty would refer to its object. It might be claimed: If our responsibility is limited exclusively to provide access to pharmaceuticals that are vital to remediate the GHC, the question is: would access to pharmaceuticals solve the problem? Surely access to medicines as such is necessary to control and solve the GHC, but it is not sufficient, it could be argued. The GHC is a multifaceted phenomenon, and thus depends on various so-called 'social determinants of health', including access to potable water, basic sanitation and healthcare infrastructure, basic education, shelter, food, etc. In this connection, pharmaceutical corporations could object that access to the pharmaceuticals they owe contributes but a tiny fraction to the control and solution of the current catastrophe, and thus their role would also be but tiny.

[467] Although the discrimination between the affected and non-affected population is key, it is worth clarifying that political boundaries or national memberships are morally irrelevant in this case: as discussed in chapter 3, one's nationality does not matter; only one's medical condition matters here.

It is true that the GHC depends on a number of social determinants of health to be properly addressed. Nevertheless, as explained in the introduction to this thesis, it is also true that the GHC is first and foremost dependent on but one social determinant of health: medical knowledge. Among all social determinants of health, medical knowledge is the most crucial for the reduction of global poverty-related deaths[468]. As the WHO argues:

> [t]he generation and utilization of knowledge – that is, scientific and technical progress – explained almost half of the reduction in mortality between 1960 and 1990 in a sample of 115 low and middle income countries, while income growth explained less than 20% and increases in the educational level of adult females less than 40%.[469]

Hence, at the core of the GHC is the lack of medical innovation/R&D, comprising both the *research* (i.e. discovery) of medical knowledge, and the *development* of such medical knowledge into adequate medicines. Access to medical knowledge is thus basic: without access to medical knowledge there will never be access to medicine. The core of the duty to remediate the GHC is therefore not only access to medicine *per se*. Prior to that, there is a fundamental question of access to medical knowledge – i.e. scientific and technical medical progress indispensible to meet basic health needs. To be sure, the problem of access to medical knowledge is thus basic to remediate the GHC: being the first problem, this is the root of the GHC. In sum, pharmaceutical

[468] Wolff, 2012b, p.94

[469] WHO, *World Health Report 2000: Health Systems: Improving Performance*, Geneva, 2000, p.9. Available at: http://www.who.int/whr/2000/en/

companies have a duty publicly to disclose only those medical patents (including substance and process, i.e. the product as well as the R&D procedure and the stored medical data used or unused by the company) that are vital to control or solve the GHC, for the limited period of time necessary for such control or solution, and only to the afflicted populations (which I have defined as the world poor affected by neglected diseases).

Conclusion

I have discussed three different theories of private property: Aquinas', Locke's, and Nozick's, and I have found that according to each of them pharmaceutical companies have a responsibility to disclose some of their medical patents in the context of the GHC. The limitations of pharmaceutical companies' patent rights are explained and instantiated differently by the three theoretical accounts: Aquinas and Locke explain the limitation of these rights based on the general idea of *superflua*, while under Nozick's account, the limitation is justified by the circumstance of avoiding a catastrophe. Independently of the theoretical premise, however, I have found out that pharmaceutical companies have a responsibility to disclose certain medical knowledge that is vital to remediate the GHC.

Part C - Defining Just Institutions[470]: How should right to health responsibilities be allocated among the agents of justice[471]?

Part C of the thesis contains chapter 5. It has the purpose of discussing the question of how to legally enforce a just allocation of right to health duties (discussed in part A) among the various right to health-related agents of justice (discussed in part B) in relation to the GHC (defined in the introduction of the thesis).

Part B has discussed who the global agents (as individuals and collectives) responsible for addressing the GHC are, and has argued that both state actors (including governments and international organizations) and non-state actors (including individuals and associations) share, as global players, certain responsibilities for the global poor and ill, afflicted by the GHC. Accordingly, the global players that are most relevant to the GHC are:[472]

State-Actors:

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[470] Rawls defines institutions as system of rules that govern our interactions with one another (*Theory of Justice*, 1971, p.55). Hurrell defines global institutions as follows: 'international institutions are made up of two elements: first, clusters of connected norms, principles, and rules (constitutive, transactional, and societal); and second, clusters of norms organized into stable and ongoing social practices. Those practices may well be connected with a formal international organization but do not need to be' (Hurrell, 'Global Inequality and International Institutions', in *Metaphilosophy*, 32:1/2, Jan.2001, pp.34-57, p.38)

Accordingly, the TRIPs regime (as a system of rules governing intellectual property globally) is a global institution.

Global agents (including state and non-state actors, considered as individuals or collectives) are part of global institutions: global agents compose these systems of rules governing the global order.

[471] I use the words agents, actors, players, and subjects interchangeably.

[472] For a detailed description of each of these actors and beyond, see: WHO/WTO/WIPO, *Promoting Access to Medical Technologies and Innovation – intersections between public health, intellectual property and trade*, 2013, p.208-12; WHO.Doc.A65/24, *Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination*, 20 April 2012, p.44; Harman, *Global Health Governance*, 2012, pp.27-88

- Governments (including their own ministries of heath and ministries of international affairs, other specialized governmental agencies, as well as governmental research organizations (e.g. national public health institutes[473], medical research councils);
- Intergovernmental Organizations: such as the UN system, which include the WHO, the WIPO, and other UN specialized agencies dealing indirectly with on health provision policies, such as the United Nations Development Programme - UNDP, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the OHCHR; the Bretton Woods institutions, which encompass the WTO, the World Bank, and the International Monetary Fund (IMF);

Non-State Actors:

- Civil Society Organizations: Non-governmental organizations, such as MSF - *Médecins Sans Frontières*, DNDi – Drugs for Neglected Diseases Initiative, UAEM – Universities Allied for Essential Medicines, ICRC - International Committee of the Red Cross, Save the Children, the International Centre for Trade and Sustainable Development (ICTSD), the International Federation of Pharmaceutical Manufactures & Associations (IFPMA), the International Generic Pharmaceutical Alliance (IGPA), the Helen Keller International (HKI), to name just a few); and the private foundations (such as the Rockefeller Foundation, the

[473] According to the WHO Report, the US National Institute of Health is the main funder of R&D for neglected diseases, providing 39.6% of the total funding in 2010. (WHO.Doc.A65/24, 2012).

Ford Foundation, the Bill and Melinda Gates Foundation[474], the Wellcome Trust, the Institute for Cancer Research, to name a few);

- Pharmaceutical companies (including their own private foundations and research institutes, such as the Merck Foundation, the Pfizer Foundation, the AstraZeneca Bangalore Research Institute, the GSK's Tres Cantos Medicines Development campus, the Genomics Institute of the Novartis Research Foundation, the Novartis Vaccines Institute for Global Health, the Novartis Institutes for Biomedical and so on and so forth);
- Individual persons (including wealthy citizens of wealthy countries, elites in developing countries, policy makers in intergovernmental organizations, CEO's of transnational corporations, scientists, etc.).

The GHC (or neglected diseases dual problem), as defined in the introduction of this thesis, is a two-fold problem: lack of access to medicine and lack of access to medical knowledge. As discussed in Part B, the crux of the GHC is lack of medical innovation (R&D) on neglected diseases, rather than merely access to medicine *per se*.

The various global players mentioned above have been engaging in a variety of partnerships among themselves in an attempt to address different aspects of the GHC (that is, different aspects of the neglected diseases dual problem). Indeed, there is today a plethora of institutions addressing the GHC, involving state and non-state actors alike, tackling different aspects of the dual problem independently. This is known as 'global

[474] According to the WHO Report, Bill and Melinda Gates Foundation is the second main funder of R&D for neglected diseases, providing 14.9% of the total funding in 2010. (WHO.Doc.A65/24, 2012).

health governance.'[475] The WHO *Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination* provides an accurate description of the global health governance's complexity in relation to the neglected disease dual problem, particularly in relation to the crux of the problem, namely lack of access to medical knowledge (medical innovation/R&D):

> There are funders and many research organizations, each taking decisions independently. In the absence of an adequately functioning market for the products of R&D, which is particularly the case for diseases mainly affecting developing countries, this is likely to result in uncoordinated decisions which do not produce the best outcome in terms of the composition of the R&D portfolio'.[476]

The global health governance is then characterized as a wide range of different global institutions,[477] composed of different global players, whose respective policies and practices tackle different aspects of the neglected diseases dual problem. These global institutions promote certain policies and practices among the players involved in the

[475] As Ruger defines it: 'the current regime of global health governance can be understood as transnational and national actors pursuing their own interests under a rational actor model of international cooperation, which fails to provide sufficient justification for an obligation to assist in meeting the health needs of others' ('Global Health Governance as a Shared Health Governance', in *Journal of Epidemiology and Community Health,* 2012, 66:7, pp.653-661, Abstract).
See also Harman's definition: 'Global health governance involves an amalgamation of various state, non-state, private and public actors and as such has developed beyond the institutional role of the WHO and state-based ministries of health. In the most basic sense of the term global health governance refers to trans-border agreements or initiatives between states and/or non-state actors to the control of public health and infectious diseases and the protection of people from health risks or threats. It is a fluid term that encompasses an ever-changing pattern of actors - both public and private, approaches and priorities for those who are in the position to govern and those who are susceptible to poor health' (Harman, 2012, p.2).

[476] WHO.Doc.A65/24, 2012, p.93

[477] By global institution I mean those systems/structures of norms ordering social policies and practices globally (see footnote 470 above).

global health governance, and impose certain burdens among them. But these policies, practices, and burdens must be morally justified: they need to correspond to the moral duties of said players. Therefore, there is a need to evaluate morally their respective roles in relation to the remediation of the GHC. Chapter 5 aims to provide a framework for evaluating these roles. It will do so by ordering the various policies and practices currently under debate, engaging with the moral principles discussed in parts A and B. The framework will distinguish, on the one hand, those global policies and practices aiming to fulfill a reason for benevolence towards the poor and ill, and, on the other hand, those global policies and practices aiming to fulfill a duty of justice towards them.

Chapter 5 – The global health governance of the GHC

This chapter will provide a framework for the moral evaluation of the global health governance, ordering its various policies and practices, according to the following criterion: the difference between reasons for benevolence and duties of justice. By categorizing the existing and proposed policies/practices according to this criterion, this chapter will be able to spot those policies/practices that are apt to impose enforceable duties with relation to the GHC, namely, justice-based policies/practices.

Although chapters 3 and 4 established an argument related to duties of justice, both chapters also give reasons for benevolence. So, I do not deny the additional motivation that benevolence provides for addressing global poverty-related issues, particularly those complex issues related to the GHC. Nevertheless, I focus here on the justice-based responsibilities to reform the current TRIPs regime in order to remediate the GHC.

As discussed in chapter 3, there are certain practices and policies that are required by justice, and not only benevolence, and that apply to all global players who are upholding the current TRIPs system. In chapter 3, I established that all global players upholding the TRIPs regime share a duty of justice (GCJ, to be more precise) to remediate the GHC. They therefore share a duty to implement certain reforms in the current TRIPs regime, correcting certain injustices that the regime inflicts upon the global poor.

Chapter 3 distinguished six scenarios: those that concern matters of justice (scenarios 1, 2, 3, and 5), and those that deal with matters of benevolence (scenarios 4 and 6). In this chapter, I will say more on how both reasons for benevolence and duties of justice have recently been implemented in the global order.

As we seen in chapter 3, scenarios 3 and 5 best capture the current global economic order under the TRIPs regime, and the GHC in particular: in these two scenarios, the realities of imminence of death, intense pain, severe suffering, and disability ground claims of both benevolence and justice. Here, in chapter 5, I will build on this premise that the GHC yields both reasons for benevolence and duties of justice, and I will here give a general and complementary account of which kinds of policies and institutions (i.e. benevolence-based or justice-based) would be justified by benevolence and/or justice.

In the context of the GHC this distinction between benevolence and justice is particularly relevant because, as discussed in chapters 3 and 4, benevolence and justice are moral virtues of different scope and substance: each virtue will ground different justifications for different types of policies/practices, with different moral forces. In the case of benevolence-based policies/practices, they require voluntary cooperation of some kind, and in the case of justice-based policies they demand compliance that might be legally enforceable. Applying this distinction between benevolence and justice within the real world of politics is relevant, as the first step global health policymakers should take to justify policy priorities, and the use of certain types of policies and practices.

The chapter is structured as follows: in section 5.1 I will explain the concepts of reasons for benevolence and duties of justice, and clarify the difference between them. Then, in section 5.2, I will categorize the main policies and practices addressing the GHC, according to what they are justified to do: either promote reasons for benevolence by coordinating voluntary cooperation (section 5.2.1), or specify, allocate and enforce compliance with duties of justice (section 5.2.2). ‘Benevolence-based policies’ are

justified by and justify the promotion of certain private conducts in cooperation with state efforts, and the coordination of these public-private conducts for the purposes of satisfying reasons for benevolence. 'Justice-based institutions and policies', on the other hand, are justified by and justify the legal (even coercive) enforcement of and compliance with certain duties, through the redefinition of certain legal rights (such as intellectual property rights).

This chapter will mention some of the most relevant examples of benevolence-based and justice-based policies and practices addressing neglected diseases' dual problem (as discussed in the introduction of this thesis). In the last section of the chapter I will analyze in further detail one particular justice-based institutional policy proposal that has been considered for addressing the GHC: the Health Impact Fund—HIF. I have chosen the HIF because its moral assessment allows us to discuss more precisely how the principles of justice examined in parts A and B of this thesis can be applied to the reality of the global health governance. The HIF is particularly interesting for this thesis because it proposes an institutional reform that invites all the relevant global players discussed in part B (namely states, influential individuals, and pharmaceutical companies) to take certain responsibilities (of justice) for the remediation of the GHC. I will show why the HIF is as a promising and complete alternative, as well as a reasonable institutional reform proposal (in accordance to the principles of justice), and a politically feasible remedy to the GHC.

5.1. Duties of Justice vs. Reasons of benevolence

What are we (as global players) morally required to do for the global poor and ill afflicted by neglected diseases? The possible answers will be based on our duties of justice or

our reasons for benevolence towards the poor and ill. These two ideas will nevertheless provide very different answers to this same question, in terms of both scope and substance.

Both duties of justice and reasons of benevolence are moral ideas: they will inform what is morally required in a particular situation. Both are relational or other-directed: both inform the limits of our actions towards others who are worse-off. Benevolence and justice will nevertheless require different sorts of actions, and require them with different force.

Justice is giving others their due, what is owed them[478]. Hence, justice has to do with rights – more precisely, justice has to do with responsibilities for other's rights[479]. If justice consists of what people have a right to, then duties of justice have correlative rights[480]. As such, they are known as 'perfect duties'[481]. Legal institutions can enforce perfect duties,[482] in order to avoid or correct a wrongdoing or injustice. They can be made enforceable through the law because rights (and therefore, justice) are obligatory: they provide a sufficient justification for compelling people to conform to it.

[478] *S.T.* ii-ii, q.58, a.1

[479] The relation between justice and rights is also explained by Waldron, 'Socioeconomic Rights and Theories of Justice', in *NYU Working Paper No.10-79*, Nov.2010, p.8; Finnis,1998, p.188; Finnis,1980, p.162.

[480] This is an uncontroversial definition, as highlighted by Buchanan, 'Justice and Charity', in *Ethics,* 97:3, 1987, 558-575, p.572.

[481] Kant distinguishes 'duties of justice' and 'duties of virtues'; the former are 'perfect duties' with correlative rights, the latter are 'imperfect duties' with no correlative rights. For this distinction, see O'Neill, *Faces of Hunger*, 1986, pp.101-2; O'Neill, *Constructions of Reasons*, 1989, p.224.

[482] When moral rights and corresponding duties provide a sufficiently strong reason for its coercion, then they are institutionalized or posited into legal rights and corresponding duties. (On the creation of legal institutions as a matter of moral duty, see Eleftheriadis, *Legal Rights*, 2008, p.56)

For example, if A steals B's bike, A has the duty of justice to return the bike to B. This duty of justice can be enforced through the law: the law can legitimately coerce A to return the bike to B, because B has private property rights over his bike. In case the bike cannot be, by any reason, returned to B, A has the duty of justice to compensate B for his loss and for his private property rights violation. A's duty of justice to compensate B correlates to B's rights to be compensated from that particular violation to his property right in the bike. The correction of the injustice suffered is precisely what is B's due: it is owed to B as B's right.

The definition of reasons of benevolence, on the other hand, is not as straightforward. For Waldron, 'charity [which is here synonymous with benevolence] is usually understood to involve a person giving part of his wealth to others who are less well-off than he is'[483]. The words 'donation' and 'philanthropy' are often used to elucidate what 'benevolence', 'beneficence' or 'charity' entails. 'Donation' or 'philanthropy' is an altruistic giving from the wealthier to the poor. What is most relevant for our purposes is that reasons of benevolence are non-enforceable. They give rise to 'imperfect duties'[484], meaning that they do not have correlative rights[485]. Beneficiaries, therefore, do not have the right to claim an altruistic giving like a humanitarian aid. Those who act on benevolence act voluntarily. In spite of being voluntary, reasons for benevolence are morally required. The degree of the moral force of reasons for benevolence will vary according to different factors. But roughly speaking, it is morally good to fulfill reasons of

[483] Waldron, 'Welfare and the images of charity', in *The Philosophical Quarterly*, 36:145, 1986, pp.463-482, p.463

[484] On the difference between perfect and imperfect duties, see O'Neill, 1986, p.101-2; O'Neill, 1989, p.224.

[485] As Grisez puts it: 'Mercy [which is here synonymous with benevolence] presupposes that a person depends on others for benefits to which he or she has no right'. (Grisez, 1993, 2.6.F.a3)

benevolence, and morally bad not to do them; yet it is not wrong (i.e. it is not an injustice, a violation of someone's rights) not to do them. This is why reasons for benevolence cannot be enforced through the law. Nevertheless, since these reasons are morally worthy, the law can legitimately promote them, and incentivize or coordinate altruistic actions.

For example, the fact that C, a wealthy individual, often gives his spare changes to the homeless, so that they can afford to spend the night in a shelter and not on the street, is something morally good. It is good that C does that; but it is not wrong if C does not do so. As a very wealthy individual, C arguably has a moral requirement to help and benefit the poor, as it brings no significant burden or inconveniences to him. Arguably, C has a duty to do much more than simply giving his spare changes to the homeless. And, arguably, C has a more stringent duty of benevolence to aid the poor, than others in the community who are not as well-off as C.

The idea of benevolence is frequently associated with the idea of the 'Good Samaritan'. Originally a biblical parable[486], it has spurred a protracted debate on the scope of the duty to aid and rescue the needy[487]. The basic idea of benevolence involves a positive action of assistance to a needy individual. This is basically what the Good Samaritan does in the parable: the Good Samaritan passed by a half-dead man who had fallen into

[486] Lk 10:30-37

[487] See for example: Fabre, *Whose body is it anyway? – Justice and integrity of the person*, 2006, pp.40-54; Feinberg, *Harm to Others – The moral limits of the criminal law*, 1987, chapter4; Weinrib, 'The Case for a Duty to Rescue', in *YLJ,* 90, 1980, pp.247-293; Ripstein, 'Three Duties to Rescue: Moral, Civil, and Criminal', in *Law and Philosophy*, 19:6, 2000, pp.751-779; Malm, 'Bad Samaritan Laws: Harm, Help, or Hype?', in *Law and Philosophy*, 19:6, 2000, pp.707-750; Mack, 'Bad Samaritanism and the Causation of Harm', in *PAPA*, 9, 1980, pp.230-259; McIntyre, 'Guilty Bystanders? On the legitimacy of duty to rescue statues', in *PAPA*, 23:2, 1994, pp.157-191; Malm, 'Liberalism, Bad Samaritan Law, and Legal Paternalism', in *Ethics*, 106:1, 1995, pp.4-31

the hands of robbers, had been beaten by them, and had his clothes stripped from him. The Good Samaritan passed by the man, and having compassion on him, stopped on his way, crossed the road, went to the man, and bandaged his wounds. The idea of benevolence as a positive action of humanitarian assistance to the needy is nevertheless very broad, because it encompasses all kinds of actions intended to benefit or help others.

One kind of morally good and helpful action is called 'easy rescue'. As its name suggest, in these cases the rescue of the needy is so easy, and the costs, burdens or inconveniences to the helper are so minimal, that some argue that it would be not only uncharitable, but actually unjust not to help. In this vein, it has been argued that the case of easy rescue is not merely a reason for benevolence, but actually a duty of justice. In this regard, there is a discussion about the so-called 'Bad Samaritan laws', which would penalize those who deny succor to those in need when the risk to the life of the rescuer is negligible. A well-known example that illustrates this debate is the hypothesis of the drowning child: suppose that a man is walking by, and sees a child drowning in a shallow pond.[488] He also sees a rope, easily at his reach that can save the child, without major costs or risks to himself. Does the man have a moral duty to throw the rope that is easily available to him, and thereby save the child? He undoubtedly has as a matter of benevolence, a compelling reason to help. But does justice require that he help the child? If so, then the law could oblige people to rescue the child in circumstances like these. In certain jurisdictions[489] that enforce 'Bad Samaritan laws'[490] it would be legally

[488] See Singer,1972, pp.229-243.

[489] For a list of jurisdictions applying Bad Samaritan laws see: Feinberg, *Harm to Others – The moral limits of the criminal law*, 1987, pp.126

wrong not to throw the rope, and neglect the dying child. But in some other countries (such as those of the Common Law tradition), this nonfeasance[491] would be, in principle, legally permissible, although this has been extensively questioned for decades. In the case of easy rescue therefore what is at stake is whether there are duties of justice here or not.

A second kind of morally good and helpful action, but strikingly different from the first kind is known as supererogatory action. *Supererogare* means to go beyond 'the call of duty', to perform more than it is required by duty, obligation, responsibility in relation to one's need.[492] As Rawls puts it: 'supererogatory acts are not required, though normally they would be were it not for the loss or risk involved for the agent himself'[493]. Supererogation therefore exceeds the requirements of ordinary morality, but is not necessarily excessively demanding, costly, or risky -- although some supererogatory actions may be seem as self-sacrificial or heroic. We could name the supererogatory agent as the Very Good Samaritan. For Joseph Raz, a supererogatory act happens when the agent, having an exclusionary reason (or 'second-order', as he calls it),

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[490] On Bad Samaritanism see: Malm, 'Liberalism, Bad Samaritan Law, and Legal Paternalism', in *Ethics*, 106:1, 1995, pp.4-31; Malm, 'Bad Samaritan Laws: Harm, Help, or Hype?' in *Law and Philosophy*, 19:6, 2000, pp. 707-750; Mack, 'Bad Samaritanism and the Causation of Harm', in *PAPA*, 9, 1980, pp.230-259.

[491] Tort law defines '*nonfeasance'* as an inaction that causes harm to a person or to property. An act of nonfeasance can result in liability if there was a duty of care toward the injured person.

[492] See *ST* i-ii, q107, q108; and *ST* ii-ii, q106*;* Feinberg, 'Supererogation and rules', in *Ethics*, 1961, 71:4, pp.276-88.

Gewirth writes: 'the philanthropic relation […] is one of supererogation. In its simplest form one person A freely gives another person B some good X […] such that A has no strict moral duty to give X to B and B has, correlatively, no claim right to receive X from A. Thus, A's gift to B is an act of generosity or charity.' (Gewirth, 'Private Philanthropy and Positive Rights'*,* in Paul et al, *Beneficence, Philanthrophy and Public Good*, 1987, 57-78, p.56)

[493] Rawls, *A Theory of Justice*, 1971, p.117

meaning 'permission', to not to act, opts to act anyway.[494] Supererogation, therefore, is different from easy rescue cases, because it is fully optional: its voluntariness is uncontroversial. Moreover, supererogation goes beyond being morally good: it is also praiseworthy. Supererogatory actions are praiseworthy to do, but not blameworthy not to do. For example, the man who throws the rope to the drowning child at the shallow pond, rescues the child, and then, in spite of been certified that the child is absolutely fine, insists on paying for swimming classes for the child. The man's extraordinary actions should bring him applause and admiration: his acts of benevolence towards the child were praiseworthy, as he performed more than was required by duty/obligation/responsibility in relation to the child's need. This is the specific element that makes supererogatory acts a special type of reason for benevolence: supererogatory acts are praiseworthy; they are fully optional, and go beyond 'the call of duty'; and, because they are laudable, they generate applause and admiration from others; hence, their further motive (i.e. ulterior purposes of the supererogatory benefactor) is often to gain a reputation for generosity[495].

In general terms, we can then identify at least three types of morally good and helpful actions: (i) the Good Samaritan-type of action (which sets the standard for ordinary morality); (ii) the Bad Samaritan-type of action (which are related to those debatable cases of easy rescue and nonfeasance); and (iii) the Very Good Samaritan-type of action (which are the supererogatory cases, fairly uncontroversial). This means that we can identify at least three categories of reasons for benevolence (with the second being

[494] Raz, 'Permissions and Supererogation', in *American Philosophical Quarterly,* 12, 161-168; Raz, *The Morality of Freedom*, 1986, p.196-197

[495] Finnis, 1998, p.142

a case where it is controversial whether that kind of action is also required as a matter of justice)[496].

Defining the precise demarcations within the sphere of benevolence, and what each of these three categories of charitable practices consists in, could spur a protracted and complex discussion. We do not need to discuss them at length here. It is sufficient for the purposes of this chapter to acknowledge their basic distinctions, and the various claims conflated under the broad idea of benevolence, so that we are able to grasp the characteristic moral force of benevolence, and then contrast it with that of justice. Benevolence is non-enforceable. There are degrees of non-enforceability among these categories of reasons for benevolence, from the clear-cut cases of strictly non-enforceable supererogation to the more complicated case of Bad Samaritanism. The enforceability of both Good Samaritan and Bad Samaritan cases is contentious, especially when they give rise to questions leading them towards easy rescue cases, which justify more stringent moral duties, or even legally enforceable duties. In spite of

[496] Those like Singer, for example, who claim that we (wealthy governments and rich individuals) are responsible for all the poor individuals of the world in any possible way, conflate all these three different spheres, and overlook their differences. Surely, these three reasons are all within the realm of charity. However, as we have seen, they yield different actions. For example, the case of the drowning child in the shallow pond, which is discussed by Singer, is an illustration of the easy rescue case. Here, the stringency and moral force of the case challenge the typical voluntariness and non-enforceability of reasons for benevolence, in a way that it might in some cases yield a duty of justice, and a legal obligation. It is therefore a case where charity overlaps with justice. On the other hand, cases of supererogation do not raise questions of justice.

Singer conflates these three reasons for benevolence. He claims that we have the following responsibility for the global poor: we have the moral duty to disrupt our own personal plans, projects and endeavors in order to save and benefit the poor and ill; we (as wealthy governments and rich individuals) have a duty to prevent and cure their poverty and diseases as much as possible by giving as much as possible of our time and resources, up until we reach the level where, if we give any more, we would cause as much harm and suffering to ourselves as we would have mitigated. This sounds self-sacrificial and heroic, and, as such, it seems to fall, in essence, under the category of supererogation -- although Singer explains his claim with examples that would pertain to the sphere of easy rescue (such as his hypothesis of the drowning child).

See Singer, 1972, p.231; and Singer, *The Life You Can Save: Acting Now to End World Poverty*, 2009.

these controversies over their degree of non-enforceability, broadly speaking, non-enforceability is the rule in benevolence.

Solving the controversies around Good Samaritan and Bad Samaritan cases is not crucial for our purpose here. For the purpose of providing a general and clear framework of global health governance, we need to make the clearest and most obvious contrasts first. So, I will first distinguish, on the one hand, those practices and policies that should always be voluntary, and thus non-enforceable, and, on the other hand, those that can be made legally enforceable, and in particular those that can be made legally enforceable through the institutional reform of certain aspects of the TRIPs legal system. Benevolence and justice therefore yield different principles of actions, and such contrast will prove to be helpful to better understand the governance behind the GHC.

5.2. Benevolence-based and Justice-based Global Health Policies and Practices

How do the concepts of benevolence and justice explained above apply to the discussion of the GHC? According to the definitions I have discussed in the previous section, the main distinction between global health-related reasons for benevolence and global health-related duties of justice is that the former are voluntary and thus non-enforceable (as reasons for benevolence do not have corresponding claim-rights), and the latter can be specified, allocated and enforced through the law (as duties of justice have a corresponding claim-right). Also, global health-related reasons for benevolence will demand a voluntary cooperation between state and non-state actors to build up the global common good, accommodating, therefore, a wide range of humanitarian aid

practices and policies[497]. Global health-related duties of justice, in turn, make more specific demands: to do or abstain from doing that which the duty of justice requires. In the context of the GHC, as discussed in chapter 2, there are duties of justice related to the responsibility to respect the right to health. This responsibility imposes two duties: the duty not to violate the right to health, and the duty to remediate violations/injustices perpetrated by the TRIPs regime. In chapter 4, I discussed specific obligations deriving from the responsibility to respect the right to health (more precisely from the duty to remediate), which applies specifically to pharmaceutical corporations: as patent-holders, pharmaceutical companies have a responsibility to disclose certain medical knowledge that is vital to remediate the GHC[498]. In this chapter I will discuss other examples of specific obligations deriving from the responsibility to respect the right to health (and more precisely the duty to remediate right to health violations inflicted by the GHC) that applies to relevant global players.

5.2.1. Benevolence-based policies/practices tackling the GHC

[497] Benevolence is greater than justice, meaning that it transcends justice. The scope of benevolence, therefore, is broader than justice, and this is why the global health-related benevolent policies/practices of humanitarian aid encompass a wider range of policies/practices in comparison to the global health-related justice policies/practices that are more specific.

[498] Chapter 2 spells out the responsibility to respect the right to health, and its two derivative duties, namely the duty not to violate the right to health, and the duty to remediate such violation. Accordingly, given that there has been a violation of the right to health of the global poor (as established in that chapter), chapter 3 explains why all global players have the duty to remediate that violation. Chapter 4 specifies why pharmaceutical companies have a special duty to remediate, as private owners of medical patents that are vital for the remediation of the crisis. Their private property can be legitimately limited because there is a GHC that inflicts a rights violation, and also because the GHC qualifies as a catastrophe in Nozick's technical sense. It is worth noting that even those who would be reluctant in accepting the GHC as an injustice, would have to accept limitations of pharmaceutical firms' private rights and their special remedial responsibilities, because the GHC qualifies as a catastrophe. As concluded in chapter 4, pharmaceutical corporations have a special kind of remedial duty in relation to the GHC, because there are some people with superfluous goods, and millions of people in dire need of them. As discussed in chapter 4, commutative justice requires these wealthy people to dispose of their superfluous goods (both Aquinas' and Locke's theory would arrive at this conclusion). But independently of whether the GHC is to some extent the product of an injustice, or not the product of an injustice at all, even libertarians like Nozick would accept the duty to dispose of goods that are vital for the prevention or remediation of a catastrophe.

Global health-related benevolent acts are humanitarian aid acts, and, as such, cannot ground claim-rights: it is morally good for global players to perform them, but no one has the right to legally demand or coerce compliance with them. They cannot be coerced or enforced through the law. The law can nevertheless incentivize, coordinate and regulate these benevolent reasons for humanitarian aid.

These benevolent reasons include all sorts of humanitarian aid programmes, and global players implement them either independently or in partnership. There are four main benevolence-based policies/practices tackling the GHC: (i) pharmacophilanthropy; (ii) differential pricing policies, (iii) voluntary licensing; and (iv) bulk buying. Let us discuss each of them in order to assess their benevolent purposes.

(i) Pharmacophilanthropy

Medicine donation initiatives are numerous[499]. They are carried out by pharmaceutical companies, often in partnership with health ministries of certain states, and the WHO. Encouraged by the UN Global Compact amid the so-called 'Corporate Social Responsibility' movement, and as part of their 'code of conduct', pharmaceutical companies have engaged in various charitable programmes. These are laudable initiatives that also contribute to pharmaceutical companies' positive public image, as good 'global citizens'. The memorable statement of 'The Johnson and Johnson Way' articulates what reasons for benevolence should mean for pharmaceutical companies: pharmaceutical firms are responsible to the communities in which the company thrives, and to the global community as a whole.

[499] For a record of medicine donation initiatives, listing the donor pharmaceutical companies, and the precise donated medicines, see: http://www.who.int/neglected_diseases/Donation_table_2012.pdf

In spite of being praiseworthy and addressing one of the two aspects of the GHC (i.e. lack of access to affordable medicine), drug donations have three downsides. First, they do not address the problem of access to medical knowledge, and therefore, does not tackle the roots of the GHC. Second, as medicine donations depend solely on the donor's generosity, these programs cannot be seen as a consistent long-term solution to the neglected diseases problem. Donors may at any time and under any circumstance cease their donations without further explanations, since donations are entirely voluntary. In the occasion of a financial recession, for instance, philanthropic policies are likely to be the first to be suspended[500]. Once the donation is suspended, the access to that particular donated drug is cut short; the treatment is thus interrupted, and this interruption may cause major health complications. Medicine donations, therefore, are not a predictable and sustainable alternative. Third, inspections reveal that donated medicines are frequently expired and often have poor quality: some are inadequately packaged or stored, which damages the formula; others are useless due to incorrect dosage or inappropriate prescription, which can be lethal[501].

Why is pharmacophilanthropy a benevolent-based policy/practice? Because it is a morally good action that global players (i.e. pharmaceutical corporations independently or in cooperation with state actors) can voluntarily do for the global poor, as a way to give back to the global order (through almsgiving to the global poor, to be more precise). Its moral status is uncertain, and depends on the circumstances of the situation. Some

[500] This does not, nevertheless, underestimate the force and stability of charity.

[501] On the problems of drug donations, see Schroeder and Singer, *Intellectual Property Rights Reform Plans – A Report for Innova-P2 (D1.1)*, CAPPE, University of Melbourne, Nov.2008, p.8; Hollis and Pogge, 2008, p 97-98.

could argue it is the special type of benevolent action called supererogation (at least on the part of pharmaceutical firms), when the action (i) is a fully optional practice; (ii) goes beyond the call of duty (since pharmaceutical corporation are not required to benefit the poor, and contribute to their health care by disposing medications to them); and (iii) it is the type of action that deserves praise, and generates applause and admiration from others, and as such it can be further motivated by the positive recognition that pharmaceutical companies (and state actors who cooperate with them) gain as good 'global citizens'. Others could argue that it is not a case of supererogation, but rather a case of easy rescue, because these donations can save the life of millions at very little cost, and under negligible burdens to the company and to state actors. Besides, if medicine donation is a case of easy rescue, it raises questions on the stringency of the moral duty to help, and on the enforceability of these reasons to help. Yet, others could argue that pharmacophilanthropy could even be justified as a matter of justice: if those donated medicines correspond to the company's *superflua* (i.e. what is superfluous, unnecessary, and excessive, as defined in chapter 4), they ought to be disposed to the poor as a matter of justice and not only benevolence[502]. Whether pharmacophilanthropy is a duty of justice on top of raising reasons for benevolence is a contentious question, and depends on the circumstances of each donation; yet, it is a common ground understanding that pharmacophilanthropy is grounded at least (and most naturally) in reasons for benevolence.

(ii) Differential pricing policies

This consists of selling the same medicine at different prices in different markets, depending on the ability of the markets to afford the treatment. There is an economic

[502] I set this argument forth in chapter 4.

explanation for this practice of differentiated prices: different markets with different demands and different purchase power justify the existence of different prices for the same commodity. Accordingly, the prices in developed countries' markets tend to be higher than the prices in developing or under-developed countries market. As discussed in chapter 4, over 80% of pharmaceutical firms' global sales are concentrated in the USA, Canada, the EU, and Japan. As these are the markets with the highest demand for pharmaceutical products, they are also the highest-priced[503]. These are indeed the major source of the pharmaceutical corporations' profits. And because developing and under-developed countries' markets lack the necessary financial capacity to buy expensive medical treatments, they are called 'neglected markets'. Although pharmaceutical corporations may have in principle an economic motivation to set discount prices for those 'neglected markets' (in developing and especially under-developed nations), the truth is that often these firms (i.e. patent-holders) do not in reality have strong incentives to keep low prices in 'neglected markets'. Quite the opposite: pharmaceutical corporations have economic reasons to raise drug's prices in those 'neglected markets' as a way to avoid the 'price leaking' problem linked to the issue of parallel imports. As discussed in chapter 4, the price leakage problem happens when a medical treatment, sold in a low-price market (typically a developing or under-developed nation), is then imported by a developed nation whose market is highly priced. The patent-holder then raises the prices in the low-price market, as a way to avoid the parallel import[504].

[503] Hestermeyer, 2008, p.161

[504] On the price leaking problem, and the parallel import question, see: Hestermeyer, 2008, p.147, 165, 231. The doctrine of international exhaustion discusses whether the TRIPs settles that a patent owner can prevent the import of the patented product from a low-priced market. The WTO concluded that members are free to establish the system of international exhaustion they consider appropriate; and the Commission on Intellectual Property Rights then concluded that 'the most beneficial policy for developing countries is to adopt a rule of international exhaustion, allowing them to purchase drugs at the lowest price at which the manufacturer offers them anywhere in the world. Developed countries, however, should not allow parallel imports in the pharmaceutical area from developing countries. This enables companies to price-discriminate and sell their products at low prices in the developing world without the price leaking into the developed world (p.231).

In principle, differential pricing policies can potentially bring an immediate alleviation to one of the two problems of the GHC, namely the problem of lack of access to medicine, as it directly tackles the issue of affordability of drugs. Nevertheless, in actuality, differential pricing policies have three downsides. First of all, similar to what happens with pharmacophilanthropy, differential pricing does not address the problem of access to medical knowledge, and therefore, does not tackle the roots of the GHC. As Pogge puts it:

> Differential pricing solutions cannot end the neglect of diseases that very rarely strike the affluent. Differential pricing can help give the poor access to a medicine at competitive market pricing only if this medicine exists. And this medicine will exist only if there is enough market demand for it also among the affluent […] Nearly all diseases and research avenues neglect under the current regime would continue to be neglected under a differential pricing regime.[505]

Second, similar to what happens with pharmacophilanthropy, differential pricing is not a predictable and sustainable alternative, because these are voluntary benevolent practices that may be ceased at any time. Third, it can disturb the international trade, when it brings about issues of price leaking and parallel imports, as discussed in chapter 4.

Why are differential pricing policies benevolent-based? Similar to what happens with pharmacophilanthropy, differential pricing policies are a morally good action that global players (i.e. pharmaceutical corporations independently or in cooperation with state

[505] Pogge, 2008, p.240

actors) can voluntarily do for the global poor, as a way to give back to the global order part of the profits and benefits they have gained from the international economic system (i.e. TRIPs regime). It could even be classified as a special type of benevolent action called supererogation at least on the part of pharmaceutical firms, when (i) it is a fully optional practice; (ii) it goes beyond the call of duty (pharmaceutical corporation are not required to benefit the poor, and contribute to their health care by giving them discounts on their sales); and (iii) it is the type of action that deserves praise, and generates applause and admiration from others, and as such it can be further motivated by the positive recognition that pharmaceutical companies (and global players who cooperate with them) gain as good 'global citizens'. Here again, differential pricing policies can arguably fall into the category of easy rescue or even of *superflua*, because the revenues that pharmaceutical companies obtain from these 'neglected markets' are negligible, and thus the burden to the company and to state players would also be negligible compared to the lives these medicines, once made cheap and available, could save. The question of whether differential pricing qualifies as easy rescue or *superflua*, raises questions on their qualification as duties of justice and on their enforceability; and here again these are contentious questions. Yet, the fact that differential pricing policies are grounded most naturally on reasons for benevolence justifies why I am here qualifying it as a benevolent-based policy/practice.

(iii) Voluntary licensing

As discussed in chapter 4, intellectual property rights provide to the patent-holder an exclusive right over his invention for a period of time of 20 years at least (article 33 of the TRIPs). Accordingly, others may only use the invention for commercial purposes if they buy a license from the patent holder, paying royalties to him. As also discussed in chapter 4, unlike compulsory licenses (article 30 of the TRIPs), voluntary licenses are

consented by patent owner[506]. Essentially, the patent holder voluntarily negotiates with the beneficiary (typically a developing or under-developed country), granting it the right to manufacture, import, or distribute a pharmaceutical product licensed to other parties, on an exclusive or nonexclusive basis, receiving in exchange the royalties for his patent. Depending on the terms of the contract, however, the beneficiary will be able to set certain conditions of sale and distribution. Voluntary licenses can allow a substantial price reduction, and thus a substantial increase in the access to the licensed medication, although the terms of the voluntary license may set price ranges and further restrictions. All will depend therefore on the terms of the license, and on the good will of the patent holder[507]. The UNITAID patent pool gives an example of the mechanism. A patent pool consists of a collection of certain patents linked to certain inventions owned by companies, universities, or governmental research institutions. The licensing of the patents to the pool is voluntarily: the patent-owners bestow their licenses to manufacturers and distributors, receiving in turn the royalties agreed on the license terms[508]. The UNITAID Patent Pool aims to accelerate the availability of generic versions of anti-retrovirals in developing countries, addressing, thus, the problem of access to medicine[509].

Voluntary licenses can lower the prices of a certain medication, and thus bring an immediate alleviation to the problem of access to medicine. It has therefore the potential to address one of the two components of the GHC (i.e. lack of access to medicine).

[506] Hestermeyer, 2008, p.239

[507] WHO, 'Voluntary Licenses', in *Essential Medicines and Health Products Information Portal*. Available at: http://apps.who.int/medicinedocs/en/d/Js4907e/3.5.html

[508] Hollis, Pogge, 2008, p.100

[509] On the UNTAID Patent Pool, see: WHO.Doc.A65/24, 2012, p.158

Nevertheless, voluntary licenses have three downsides, just as happens with pharmacophilanthropy and differential pricing. First of all, voluntary licenses do not address the problem of access to medical knowledge, and therefore, do not tackle the root of the GHC. Second, voluntary licenses are not a predictable and sustainable solution: the license is voluntary, and contingent on the contractual terms that may be very restricting. Also, a third problem is this: because the manufacturing capacity of the beneficiary is crucial in this case, poor countries many times cannot really use the mechanism and enjoy its potential benefits, because they do not have the required domestic technological capacity to produce the product: without technology transfer, therefore, voluntary licenses are useless to poor countries with poor manufacturing capacity. In fact, voluntary licenses are usually motivated by strategic market reasons (to gain the favors of and enter into one specific market, for example); it does not have, therefore, the primary purpose of serving as an access to medicine alternative -- although it could technically have this additional potential benefit.

Why are voluntary licenses benevolent-based policy/practice? In principle, the idea of voluntary licenses is justified as a morally good action that pharmaceutical corporations can voluntarily do for the benefit of the global poor. Similar to what happens with pharmacophilanthropy and differential pricing policies, voluntary licenses could also be classified as supererogation, when (i) it is a fully optional practice; (ii) it goes beyond the call of duty (pharmaceutical corporation are not required to benefit the poor by disclosing patent rights under normal circumstances[510]; and (iii) it is the type of action that deserves praise, and generates applause and admiration from others, and as such it can be further motivated by the laudable recognition that pharmaceutical companies (and state

[510] The exceptions (i.e. *superflua* and catastrophe) have been discussed in chapter 4

actors who cooperate with them) gain as good 'global citizens'. Here again, similar to what happens with pharmacophilanthropy and differential pricing policies, voluntary licenses can arguably fall into the category easy rescue or even *superflua*, because the revenues that pharmaceutical companies obtain from the global poor/'neglected markets' are minimal, and so the burden to the company and to other global players would also be minimal, compared to the millions of life that these medicines, once made available, could save. The question of whether voluntary license qualifies as easy rescue or *superflua*, and thus whether it qualifies as an enforceable duty of justice, is here again contentious, and dependent on the circumstances. Yet, voluntary licensing can be a benevolent-based policy/practice when it is grounded on reasons for benevolence, independently of the patent-holder's ulterior purposes linked to his strategic market intentions, or his willingness to receive praise, applause and admiration. Voluntary license is most naturally seen as a benevolence-based action, particularly because, as a characteristic of benevolence-based actions, it cannot be enforced through the law: voluntary licenses are voluntary.

(iv) Bulk buying

Civil Society organizations – including non-governmental organizations and private foundations – take bulk buying of drugs as one of their main strategies in their advocacy for better access to medicines. The strategy is as follows: the civil society organization negotiates with the pharmaceutical company a reduced priced for the acquisition of a large quantity of the needed drug. Similar to voluntary license, bulk buying can be used as a market strategy for pharmaceutical companies: through bulk buying, a company can gain favours and enter into one specific market, for example. So, bulk buying is not really an access to medicine alternative -- although it can have this additional benefit.

So, bulk buying can be effective in acquiring medicines for a lower price, having thus the potential to bring a short-term alleviation to the problem of access to medicine. Nevertheless, bulk buying is marred by the same problems of the other benevolence-based policies: first, bulk buying does not address the problem of access to medical knowledge, and therefore, do not tackle the roots of the GHC; and second, bulk buying is not a predictable and sustainable solution, as it depends on the good will of the civil society organization and the pharmaceutical company negotiating the contract[511].

As with other policies seen in this section, bulk buying *can* be benevolence based. Similar to other benevolence-based policies/practices, bulk buying can be justified as a morally good action that global players (state and non-state actors alike) can do to benefit the global poor. Bulk buying could be seen as a case of easy rescue or *superflua*, in the same way than other benevolence-based policies/practices. The question of whether bulk buying qualifies as easy rescue or *superflua*, and thus whether it qualifies as an enforceable duty of justice, is here again contentious, and dependent on the particular facts of the case. Yet, bulk is most naturally seen as a benevolence-based action.

In sum, the four policies/practices discussed above can be benevolence-based because they have in common at least (i) the fact that they are morally good actions; and (ii) the fact that are voluntary, and thus non-enforceable through the law. In the case of benevolence-based policies/practices therefore the crucial feature is that the global poor cannot legally claim or demand global players to do them: they are a matter of voluntary benevolence.

[511] On the problems of bulk buying, see: Schroeder and Singer, 2008, pp.10-11; Hollis and Pogge, 2008, p.100.

5.2.2. Justice-based policies tackling the GHC

As I have discussed in section 5.1, justice has to do with rights: it tells what is due or owed to others, and what others have a right to[512]. As discussed in chapter 3, the Thomistic idea of justice emphasizes the communal aspect, having coined the term 'commutative justice', which orders the inter-relations between individual parties, bearing upon one another towards the common good. The idea of commutative justice spurs the underlying responsibility to respect, protect, and fulfill the common good, which gives rise to communities as well as relationships of solidarity among individuals and groups. In this way, there is a shared responsibility to form (meaning participate, uphold) and reform the communal institutions[513]. Based on this Thomistic conception of commutative justice, I have, in chapter 3, spelled out the idea of GCJ, which orders the inter-relations between global players individually considered, bearing upon one another towards the global common good. In view of that, there is a shared responsibility to form and reform common institutions when they are not respecting and building up the global common good. This section of the chapter will discuss certain institutional reforms that address the GHC, in order to spot the institutional policies/practices that are justified in imposing enforceable remedial duties with relation to the GHC.

Global health-related duties of justice (GCJ, to be more precise) have a definite scope: they address what we (as global players – i.e. an individuals and collectives) owe one

[512] See *ST* ii-ii, q.58,a.1.

As Grisez puts it: 'Justice requires respect for others' fundamental rights and fulfillment of commitments' (Grisez, 1993, 2.7.G.1a).

[513] See Grisez, 1993, 2.6.B.5b; Finnis, 1980, pp.184-8

another in terms of our health-related rights and duties.[514] It is morally right for duty-bearers (i.e. wealth governments, wealthy citizens, and pharmaceutical companies, as discussed in chapters 3 and 4) to fulfill these duties not only by performing (i.e. participating and upholding) the actions they require (or abstaining from those they prohibit), but also by reforming current institutions so as to make them consistent with those duties. Because this is a matter of justice, others have the right and reason to demand our compliance for the sake of the global common good.

Legal institutions can enforce duties of justice: they can enforce duties of justice through the reform of certain legal rights (such as intellectual property rights) in order to remediate an injustice. Elizabeth Ashford writes:

> The primary focus of obligations of justice is the shape of social institutions. First, the purview of obligations of justice is the equitable resolution of competing interests across the community as a whole, or, in the case of human rights, across global social institutions and the international community. Second, obligations of justice ought to comprise a scheme of institutionally articulated,

[514] As discussed in chapter 3, the Thomistic idea of justice emphasizes the communal aspect, having coined the term 'commutative justice', which orders the inter-relations between individual parties, bearing upon one another towards the common good. The idea of commutative justice spurs the underlying responsibility to respect, protect, and fulfill the common good, which gives rise to communities as well as relationships of solidarity among individuals and groups. In this way, there is a shared responsibility to participate, to uphold, and to form and reform the communal institutions. (See Grisez, 1993, 2.6.B.5b; Finnis, 1980, pp.184-8.)

Based on this Thomistic conception of commutative justice, I have, in chapter 3, spelled out the idea of GCJ, which orders the inter-relations between global players individually considered, bearing upon one another towards the global common good. In view of that, there is a shared responsibility to reform common institutions when they are not respecting and building up the global common good. This section of the chapter will discuss certain institutional reforms that address the GHC.

> coordinated, and enforced collective action that ensures that the corresponding rights are universally fulfilled.[515]

Based on Ashford's definition, we can say that global-health duties of commutative justice ought to comprise a scheme of institutionally articulated, coordinated, and enforced global policies that ensure that the corresponding right to health (a basic human right, as defined in chapters 1 and 2) is universally fulfilled. Global-health duties of commutative justice therefore are not only morally required as a matter of respecting/not violating the global common good, but they can also be legally enforced in order to remediate an injustice (i.e. a breach of duties of justice) within the current system. Global-health duties of commutative justice are therefore two-fold, as explained in chapter 2: they entail a duty not to violate, and a duty to remediate violations, such as those that the GHC inflicts.

Global-health duties of commutative justice therefore justify the reform of certain legal rights, such as intellectual property rights, in order to remediate rights violations, such as the violation of the right to health that current intellectual property regime inflicts. As explained in the introduction of this thesis, the GHC is an outcome of market failures within the TRIPs. In actuality, the crisis is not merely a market failure, but also an injustice resulting in the right to health violation of millions of people in the world. It is argued that the TRIPs regime is unjust because it introduces certain barriers to the right to health of poor citizens in developing countries that did not exist before 1994 (when the TRIPs Agreement was adopted). These are legal barriers, which are imposed by the

[515] Ashford, 'Obligations of Justice and Beneficence to Aid the Severely Poor', in Illingworth, Pogge, Wenar, *Giving Well – The Ethics of Philanthropy*, 2011, p.30

new intellectual property laws assembled under the TRIPs Agreement. Some of the TRIPS effects are unjust because they worsen-off the poorest populations[516].

Injustice has to do with violation of rights. Accordingly, the TRIPs rules are unjust only if they violate certain rights of the poor, and make them worse-off. In chapter 2 we have argued that, despite much debate regarding the scope of the duties arising from the right to health, it is generally accepted that the (basic) right to health entails the (basic) responsibility to respect -- i.e. the duty not to violate the right to health of others, as well as the duty to remediate such violation. As also discussed in chapter 2, the (basic) right to health can fail to be respected by X when X avoidably makes less secure the access to the object of such right (i.e. the satisfaction of the basic health needs, as defined in chapter 1).

Before 1994, the poor had secure access (or at least better access) to their basic health needs. As Pogge puts it:

> Before the TRIPS Agreement was adopted, most of the less developed countries had weak intellectual property protections or none at all, which enabled them to produce or import cheap generic versions of advanced medicines that were patented and thus much more expensive in the affluent countries. Relative to the Pre-TRIPS, status-quo thus impose a serious loss on the poorer three quarters of the human population by pricing out of their reach new medicines that otherwise they could have obtained at generic prices either through their own

[516] This argument is set forth in Hollis, Pogge, 2008, p.53

efforts or with the help of friends, relatives, NGOs, or governmental and intergovernmental agencies.[517]

The TRIPs worsened-off the poorest populations inasmuch as they must now pay much higher prices for certain medicines, without which they cannot live a minimally decent life. Certainly, poverty has always existed. However, by comparing the pre-TRIPs regime, and the current regime, evidence shows that before 1994 the poor could more easily obtain new medicines at generic prices[518]. For example, the poorest countries (even if they did not have any producing capacity to manufacture the generic versions themselves), could import these much-needed generic versions from developing countries like Brazil, India or Thailand, whose generic drug industries by 1994 had a good producing capacity. In this connection, and as argued in chapter 2, the current TRIPs regime is unjust because it worsens-off the poor's capacity to fulfill their own basic health needs, and thereby violates their (basic) right to health.

If the GHC inflicts a violation of the right to health, then this justifies the duty of justice to remediate the situation[519]. The key point I want to stress here about justice-based policies addressing the GHC is this: justice-based policies can consist of certain systemic reforms, such as the reform of certain legal rights (e.g. intellectual property rights), in the specific aspects where there has been a justice deficit (i.e. a right violation); and such systemic reforms ought to be not merely a correction or rectification of a problem, but above all reflect a long-term, sustainable and definite commitment to

[517] Ibid

[518] Ibid

[519] See chapter 2.

uphold the global common good. This is so because the global-health duties of commutative justice requiring the respect of the right to health further demands not merely the obligations not to violate and to remediate the violation, but also and concomitantly the duty to uphold the global common good through institutions that aptly reflect the relevant duties of justice.

So, while benevolence-based policies are pejoratively called 'band-aid' solutions to systemic problems, as they typically serve merely as a temporary or expedient remedy, justice-based solutions can aim precisely at proving systemic solutions to systemic problems, in a long-term committed, sustainable and definite way. The justice-based policies addressing the GHC aim, by and large, at a long-term committed, sustainable, and systemic solution of the neglected diseases dual problem[520]: they propose to correct the failures of the TRIPs system, by finding an alternative way to incentivize the research/discovery of neglected diseases, and to develop affordable and adequate medicines for them.

The justice-based policies addressing the GHC will therefore ideally aim not only to incentivize research/discovery of new medical knowledge for neglected diseases treatment, but also to make new or existing formulations available at affordable prices. So, the most complete justice-based policies will be those able to tackle both fundamental aspects of the GHC: they will be able to tackle the root of the GHC (i.e. lack

[520] As defined in the introduction of the thesis, the GHC is fundamentally an issue of R&D on neglected diseases: it is problem of lack of research, and a problem of lack of right to use developed and thus patented medicines. The GHC emerges thus as a dual problem of unavailability of both medical knowledge and medical technologies for treating neglected diseases. The first problem relates to the lack of access to medical knowledge (i.e. research/discovery) and the second problem relates to the lack of access to medicines (i.e. developed medical technologies).

of access to medical knowledge on neglected diseases), while also tackling the following problem of access to adequate and affordable medicines for neglected diseases.

Justice-based policies can take, as we shall see below, three main forms: the so-called 'push' mechanisms, the 'pull' mechanisms, and the combined alternatives. Push mechanisms are funding policies: they incentivize R&D by reducing its costs. They do so by financing one chosen researcher, and rewarding him by his efforts. The push mechanism *pushes* the chosen research into making a good effort. Pull mechanisms, on the other hand, incentivize R&D by creating a market demand for a certain socially valuable innovation. The pull mechanism *pulls* potential researchers into a competition, and rewards the successful inventor for his achievement. So, as we will see below, while the former mechanism rewards the researcher for his effort, the latter pays only according to his achieved performance[521]. We will now discuss multiple examples of push and pull mechanisms in order to be able to spot the most promising ones – by the most promising I mean not only the most complete for tackling both fundamental problems of the GHC, namely access to medical knowledge and access to developed medicine, but also the most apt for committing persistently the relevant global players, such as wealthy states, wealthy citizens, and pharmaceutical corporations.

(i) Push mechanisms

Push mechanisms incentivize R&D by providing funding. A great part of the existing policies tackling the neglected diseases problem falls into this category. There are two main kinds of push mechanisms for neglected diseases: 'Publically Funded Research Grants' and 'Product Development Partnerships'.

[521] See Schroeder, Singer, 2008, p.13; Hollis, Pogge, 2008, p.100, 103.

In publically funded research grants, a state actor, often in partnership with a funding research institution, pays research grants for neglected diseases. The public funding incentivizes research/discovery on a particular neglected disease. The European and Developing Countries Clinical Trials Partnership is an example: since 2003, European taxpayers have been supporting researches on HIV/AIDS, TB and malaria[522].

Product development partnerships are, in general, public-private partnerships: a state actor collaborates with non-state actors, typically a pharmaceutical firm and another civil society organization (such as NGOs, private foundations, research institutions, universities, etc), and provides funding for research on one particular neglected disease[523]. There are numerous examples of product development partnerships: the IAVI – International AIDS Vaccine Initiate[524], the Global Alliance for Tuberculosis Drug Development[525], the MMV - Medicines for Malaria Venture[526], and the DNDi to name only a few. In actuality, the majority of the existing responses for the problem of

[522] Schroeder, Singer, 2008, p.13

[523] See Hollis and Pogge, 'Product-Developmemt Partnerships and the Health Impact Fund', in *IGH Discussion Paper N.9*, 4Dec2010.

[524] IAVI is a global not-for-profit organization whose mission is 'to ensure the development of safe, effective, accessible, preventive HIV vaccines for use throughout the world'. Its works with partners in 25 countries to research, design and develop AIDS vaccine candidates. Other collaborators include: the World Bank, Bill and Melinda Gates Foundation, the USaid, the UKaid, companies such as GSK, Bristol-Myres Sqibb, Google, and many others. See http://www.iavi.org/Who-We-Are/Leaders/About-Us/Pages/default.aspx.

[525] The TB Alliance's mission is 'to discover and develop better, faster-acting, and affordable drugs to fight tuberculosis'. Among the donors are: Bill and Melinda Gates Foundation, the USaid, the UKaid, The Australian Aid, the European Commission, UNITAID, FDA, etc. See http://www.tballiance.org/about/donors.php.

[526] MMV is 'a not-for-profit public-private partnership', whose mission is 'to reduce the burden of malaria in disease-endemic countries by discovering, developing and facilitating delivery of new, effective and affordable antimalarial drugs'. Among its donors, there are: the WHO, the World Bank, Bill and Melinda Gates Foundation, the Rockefeller Foundation, the Wellcome Trust, the USaid, the UKaid, the Swiss Agency for Development and Cooperation, the Spanish Agency for International Cooperation, the Netherlands Ministry of Foreign Affairs, Exxon Mobil, among others. See http://www.mmv.org/about-us/our-donors.

neglected diseases are under the form of product development partnerships. As mentioned in chapter 4, most recently, international organizations, such as the WHO, WIPO, and WTO have been favoring the so-called 'Open Innovation' approach in product development partnerships. They support the open innovation approach since it advocates the public disclosure of certain medical data (such as those that might be relevant for neglected diseases), and their maintenance in public libraries, such ChEmBL, PubChem, GSK's Tres Cantos Open Lab Foundation, WIPO Re:Search, Pfizer and Academic Centres for Therapeutic Innovation, and Eli Lilly's Open Innovation Drug Discovery[527]. In these public libraries, independent researchers have open access to pharmaceutical companies' data banks, and they can continue the research experiments that seem most promising. Under the open innovation approach, these independent researches can discover and further develop knowledge that is free to be used without any legal/contractual restriction imposed by patent rights. If *superflua*, as discussed in chapter 4, are those things that owners have, but do not need, this unused medical data that pharmaceutical firms would lose and waste anyway can be considered pharmaceutical firms' *superflua*. As such, this unused medical data ought to be disposed to benefit of the poor as a matter of justice and not only benevolence. Justice (i.e. GCJ) requires pharmaceutical firms to disclose this medical data to public libraries, making public this specific part of their private property (namely their unused medical data), under the justification of avoidance of useless waste.

Indeed, a number of pharmaceutical companies have already been contributing to the R&D on neglected diseases, in cooperation with other state and non-state actors, through numerous product development partnerships. In 2012, there were 132 research

[527] Sheridan, 'Industry continues dabbling with open innovation models', in *Nature Biotechnology*, 2011, pp.1063-1065

projects for the R&D of new medicines and vaccines for neglected diseases; of these, 112 are under the form of a product development partnership, involving *inter alia* the Merck Foundation, the Pfizer Foundation, the AstraZeneca Bangalore Research Institute, the GSK's Tres Cantos Medicines Development campus, the Genomics Institute of the Novartis Research Foundation, the Novartis Vaccines Institute for Global Health, the Novartis Institutes for Biomedical and so forth.[528] Also, in 2012, under the London Declaration on Neglected Tropical Diseases, 13 pharmaceutical transnational corporations in cooperation with several state and non-state actors agreed to advance R&D for 10 neglected tropical diseases. The partnership aims to fund researches for the control and elimination of these illnesses by 2020[529].

The advantage of these two kinds of push mechanisms (namely the publically funded research grants and the product development partnerships) is that they allow the funding to be directed to the most pressing neglected diseases, for which there is no adequate treatment available[530]. They can thereby address the root problem of access to medical knowledge. There are, however, two main downsides. First, push mechanisms do not pay according to performance, and therefore they may end up subsidizing some unsuccessful R&D attempts (it is worth remembering here that R&D of pharmaceuticals

[528] WHO/WTO/WIPO, *Promoting Access to Medical Technologies and Innovation – intersections between public health, intellectual property and trade*, 2013, p.122

[529] Following the WHO's *2020 Roadmap on Neglected Tropical Diseases*, the international community – including The World Bank, non-government organizations, individual donors, endemic countries, developed countries, and 13 pharmaceutical transnational corporations *(*Abbott, AstraZeneca, Bayer, Bristol-Myers Squibb, Eisai, Gilead, GSK, Johnson & Johnson, Merck KGaA, Merck Sharp & Dohme (MSD), Novartis, Pfizer and Sanofi*),* - endorsed the *London Declaration on Neglected Tropical Diseases*, on 30 January 2012, affirming their public commitment to do their share to advance R&D through partnerships and provision of funding to find next-generation treatments. The 2012 London Declaration is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67443/NTD_20Event_20-_20London_20Declaration_20on_20NTDs.pdf

[530] Hollis, Pogge, 2008, p.101

is highly costly especially because it is highly risky: many R&D attempts fail). As a consequence, the price of those successful formulas will inevitably be high, in order to allow innovators to recoup the costs of the failed attempts. This means that, although push mechanisms can potentially address the root cause of the GHC (i.e. the problem of lack of access to medical knowledge), they do not fully address the problem of access to affordable medicines. Second, push mechanisms are not necessarily long-term and sustainable solutions, unless they are complemented by a long-term committed source of funding. Like benevolence-based policies, the funding in push mechanisms can also be contingent on state actors' and funding bodies' changing political priorities and good will. As Pogge puts it:

> Push programs may lack stability over long-term. Publically funded grant programs and grants must be frequently re-approved, and often terminated. Philanthropic support for research may dissolve as sponsors' priorities change […] and financial support will shift together with the interests and sympathies of funders.[531]

In sum, push mechanisms (namely publically funded research grants and product development partnerships) can be justified by reference to certain requirements of justice: they can rectify an injustice either through a legal enforcement, or through a systemic legal reform. Therefore, push mechanisms are classified as justice-based policies addressing neglected diseases, because they can be enforced through the law (e.g. tax law enforces upon Europeans their contribution to the publically funded research grants to the European and Developing Countries Clinical Trials Partnership) or

[531] Ibid, p.103

they propose a systemic reform for the rectification of the system precisely where the injustice occurs (e.g. the open innovation approach is a systemic alternative: it reforms certain legal rights protecting intellectual enclosure, and introduces a systemic alternative to the TRIPs regime based on openness). Yet, push mechanisms are not a complete alternative to the neglected diseases dual problem: they do not fully address the problem of access to affordable medicines, and they do not usually provide a long-term, sustainable and definite solution. As discussed above, global-health duties of commutative justice require not only the rectification of injustices through certain systemic reforms, in the specific aspects where there has been a justice deficit (i.e. a right violation); such systemic reforms ought above all also to reflect a long-term, sustainable and definite commitment to uphold the global common good. Although push mechanisms make a valuable justice-based contribution to the GHC, they are not the most complete alternative.

(ii) Pull mechanisms

Pull mechanisms incentivize R&D by creating a market demand, and rewarding the successful inventor for the achievement of a socially valuable innovation. The existing TRIPs system is an example of a pull mechanism, since it incentivizes and recompenses the successful inventor of a socially valuable innovation with patent rights and market monopoly. Given that neglected diseases are a market failure produced by the patent regime, the pull mechanisms aiming to incentivize R&D on neglected diseases will need to have a different strategy of incentive and compensation. I will discuss below two examples of pull mechanisms: the priority review voucher, and the purchase or procurement agreements (also known as advanced market commitment).

The priority review voucher was passed into law in the USA, through the 2007 FDA Amendment Act. It gives the pharmaceutical company a voucher to claim an expedited or priority FDA review for a pharmaceutical, every time the same company registers a drug for one of the 16 listed neglected tropical disease. This is interesting for pharmaceutical companies since the abbreviated approval of the second drug can add a substantial profit to the company[532]. Also, vouchers can be sold to other companies. Since 2007, when this scheme was introduced in the USA, two priority review vouchers have been issued: in 2009, the first priority review voucher was issued for the development of an anti-malarial, and in 2012, the second one was issue for an anti-TB[533].

The priority review vouchers have the typical advantage of pull mechanisms: it does not pay for failed researches. Also, in principle, they incentivize R&D for new neglected diseases treatment, and thus, in principle, they address the problem of lack of access to medical knowledge. Yet, in reality, they fail to address this problem fully because 'the value of the voucher is too small to have meaningful impact on the allocation of R&D resources by large pharmaceutical companies'[534]. And they do not address by themselves the problem of unaffordable existing treatments (i.e. the problem of lack of access to medicines), since pharmaceutical firms would still be able to charge exorbitant

[532] 'The voucher could reduce the time required to gain FDA approval of the second drug by up to one year. The additional profit that a pharmaceutical innovator could earn from this additional year of market exclusivity is estimated at more than 4300 million for a blockbuster drug' (Ibid, p.104)

[533] WHO/WTO/WIPO, *Promoting Access to Medical Technologies and Innovation – intersections between public health, intellectual property and trade*, 2013, p.119

[534] Ibid

monopoly prices for the neglected disease drug developed through a priority review voucher[535].

Purchase or procurement agreements are legal contracts where the purchaser (typically, a state actor, e.g. a government or an international organization) promises to buy a certain quantity of new vaccines to be developed, as long as certain predetermined specific requirements are achieved. In 2007, the governments of Canada, Italy, Norway, the UK and the Bill and Melinda Gates Foundation funded a pilot purchase or procurement agreement for the development of vaccines for pneumococcal disease, fixing an affordable predetermined price for the treatment as a condition of purchase.

Purchase or procurement agreements also have the typical advantage of pull mechanisms: it does not pay for failed researches. Moreover, in principle, they can address both the problem of lack of access to medical knowledge (by incentivizing R&D on new treatment for neglected diseases), and the problem of lack of access to medicine (by requiring affordable prices for the treatment as a condition for the purchase). Yet, purchase or procurement agreements have shown two main downsides in real application. First, given that the purchase contract requires a high degree of specification in its terms and conditions, this may hinder the R&D process by adding and imposing various details that may become further obstacles, and these may delay or even restrict the potential successes of the R&D process. Second, the pilot for the pneumococcal disease has been criticized for paying an excessive price for said vaccine (it is claimed that its R&D was already in the latest stages when the contract was signed, and

[535] Schroeder, Singer, 2008, p.16

therefore the vaccine would have been introduced into the market even without the agreement)[536].

Pull mechanisms (namely priority review voucher and purchase or procurement agreements) can be justified by reference to certain requirements of justice: they create a complementary legal alternative that incentivizes and recompenses the successful R&D results in areas where the TRIPs and its side-effects unjustly impede this to happen. These pull mechanisms are justice-based policies addressing neglected diseases because they are justified by the duty to remediate certain injustices that the TRIPs inflicts in relation to neglected diseases. These pull mechanisms remediate said injustices using the same legal rationale of the TRIPs: the TRIPs promotes and coordinates R&D incentives and recompense for the successful results through patent rights and market monopoly; likewise, the pull mechanisms mentioned above promote and coordinate R&D incentives and recompense for the successful results, either through the rights conferred by the priority review voucher, or through the contractual promise of recompense conferred by the purchase or procurement agreement.

Both pull mechanisms discussed here are justice-based because they are legal mechanisms that are justified by a duty of justice, namely the duty to correct certain injustices introduced by the TRIPs regime; and this duty of justice can be made enforceable. These two pull mechanisms justify the correction or reform of certain aspects of the TRIPs, by complementing the current system, precisely in the areas where the TRIPs fails (i.e. neglected diseases dual problem).

[536] Hollis, Pogge, 2008, p.107

Some could argue that purchase or procurement agreements, for example, are no different from certain benevolence-based policies, such as bulk buying, differential pricing policies, or voluntary licenses, as they are all providing a contractual incentive and recompense for altruistic state and non-state actors to help the poor out of their good will. Surely, in all these cases the law creates a legal institution (i.e. contract) to coordinate and promote benevolence for the poor. Yet, in the particular case of purchase or procurement agreements, the law is *also* justified by a reason of justice: these purchase or procurement agreements are *also* justified by the *duty* to remediate the lack of access to medical knowledge and affordable medicines for neglected diseases, exacerbated as a side-effect of the TRIPs. They are not justified only as a voluntary action that the wealthier part in the contract opts to take to favor the poor. In the case of purchase or procurement agreements there is *also* a duty of justice that is enforceable, as it correlates to the violation of the right to health, inflicted as a side-effect of the TRIPs. The benevolence-based policies (namely differential pricing policies, voluntary licenses, and bulk buying), by their turn, can be justified first and foremost by the need to help the poor, rather than by considerations of justice, because they are not systemic solutions to the systemic crisis, but rather 'band-aid'/expedient remedies to a systemic problem (as discussed in section 5.1 above). It is useful to bear in mind that justice based-policies can always be benevolence-based, but not the other way around: the justice-based policies, in avoiding or remediating an injustice, provide a benefit. Therefore it is possible to do justice for the sake of benevolence: to do justice for someone *also* because it is good for that person (benevolence). This does not conflate justice and benevolence, but it shows that any justice-based policy can be conceived as a benevolence-based policy as well. What matters here is that some policies can be justified *also* by considerations of justice (and others cannot), and therefore are justified in imposing coercive measures through the law.

So, pull mechanisms (namely priority review voucher and purchase or procurement agreements) can therefore be classified as justice-based policies addressing neglected diseases, because they are typically justified by reference to duties of justice—which, of course, does not mean that they could not also be justified in terms of benevolence.

Although pull mechanisms make a valuable justice-based (on top of benevolence-based) contributions to the GHC, they are not the most complete alternative to the neglected diseases dual problem: as discussed above, first, they do not fully address the problem of lack access to medical knowledge; second, they either do not address fully the problem of access to affordable medicines (e.g. purchase or procurement agreements), or they do not address it at all (e.g. priority review vouchers); third, they do not provide a long-term, sustainable and definite solution to the GHC. Therefore, like push mechanisms, pull mechanisms also fail to reflect a long-term, sustainable and definite commitment to uphold the global common good, and thus fail to fully comply with the requirements of GCJ, in spite of their contributions to the GHC.

(iii) Combined Pull and Push Institutional Reform Proposals

I will discuss here two combined pull and push institutional reform proposals: the Medical R&D Treaty, and the HIF. As we will see, both proposals are justice-based polices: if approved, they will be enforceable legal mechanisms (i.e. each would be established by an international treaty that would enforce their requirements upon their parties); also, they aim at implementing a systemic alternative to the TRIPs regime, correcting it where it fails, and thus complementing it for the sake of the global common good in a sustained committed way.

These are justice-based policy proposals. Yet, it is worth emphasizing here again that any justice-based policy can also be grounded in benevolence, and, as such, both reform proposals to be discussed below are grounded in both justice and benevolence.

5.2.3. The Medical R&D Treaty Proposal

The Medical R&D Treaty was submitted to the WHO in 2005, with the support of academics, NGOs, governments, and other private institutions. It seeks 'to create a new global framework for supporting medical R&D that is based upon equitable sharing of the costs of R&D, incentives to invest in useful R&D in the areas of need and public interest, and which recognizes human rights and the goal of all sharing in the benefits of scientific advancement'[537]. In 2012, the WHO elected it the best institutional reform proposal for the TRIPs regime, addressing neglected diseases[538]. Under said treaty, member-states would agree to fund the R&D of certain pharmaceuticals for neglected diseases; and a committee of representatives from these member-states would define the research agenda. According to the proposed architecture, there would be an R&D fund, and the research results would not remain under the monopoly of the researcher/innovator. Rather, the research outcome would be disclosed to the public domain, to be commonly shared, in order to 'promote equitable access to new medical technologies so that all people share in the benefits of scientific advancement'[539].

[537] James Love, *Medical Research and Development Treaty*, 2005. Available at: http://www.cptech.org/workingdrafts/rndtreaty4.pdf, p.2

[538] WHO.Doc.A65/24, 20 April 2012.

[539] Ibid, p.134

This reform proposal has several strengths, and the WHO expert working group ranked the proposed treaty very highly. First, as a pull mechanism, it would pay only for performance. Second, it would potentially tackle both problems amounting to the GHC, namely lack of access to medical knowledge, and lack of access to medicines: the treaty aims to incentivize the R&D of subsidized and thus affordable new medicines. Third, by its design as a binding international treaty it would secure a long-term and stable source of funding: the treaty aims to provide effective financing and coordination of efforts for the promotion of R&D, enforcing all member-states to invest 0.01 of their GDP in R&D for type 2 and type 3 diseases[540].

In principle, this treaty aims to secure a sustainable and definite systemic commitment to ordering the inter-relations among the relevant global players (including state actors, pharmaceutical firms, private foundations, research institutions, research universities and NGOs), towards the global common good, and with a preferential option for the global poor, as it is specially addressing the problems of neglected diseases. The treaty proposal shows a special concern for the global poor in at least two ways: (i) it has the potential to advance research priority setting based on the public health needs of developing and under-developed countries (rather than on market preferences), and to incentivize the innovation of new health technologies particularly relevant for the global poor (addressing thus the problem of lack of access to medical knowledge); and (ii) it has the potential to enhance the development of the innovative capacity of developing countries, through an open approach to intellectual property (addressing thus the problem of lack of access to medical knowledge), and through technological transfer.

[540] WHO/WTO/WIPO, 2013, p.120

In this sense, the purposes of the Medical R&D Treaty are, in principle, aligned with the requirements of GCJ that have been discussed in this thesis. The treaty aims to provide 'incentives to invest in needs-driven R&D consistent with human rights and with the goal of all sharing in the benefits of scientific advancement. This will involve norms and obligations on both national governments and international institutions.'[541] The treaty aims therefore to provide a mechanism that gives priority to the basic health needs of the poor. As discussed in chapter 2 of this thesis, basic health needs constitute the object of the (basic) human right to health, and they will also justify the content and force of the (basic) duties correlated to the (basic) human right to health. These duties are universally shared: as discussed in chapter 3, all global players share a GCJ responsibility to respect and uphold the global common good, and this implies at least the responsibility to respect the (basic) human right to health of others. As explored in chapter 2, the responsibility to respect is the common ground among policy makers and theorists; and it further generates two duties: the duty not to violate other's right to health, and the duty to remediate its violation. The idea of the GCJ therefore justifies the Medical R&D Treaty as follows: as discussed in chapter 2, given that the existing TRIPs structure imposes avoidable obstacles to the poor's secure access to their basic health needs, there is a breach of the responsibility to respect the human right to health—a duty which is accepted by all the relevant players in the debate. Consequently, the principles of GCJ justify the duty to remediate this violation that amounts to the GHC[542]. The Medical R&D Treaty aims to rectify precisely this structural problem within the TRIPs, which I call the GHC, while at the same time building the global common good up by considering the rights and duties of different global players that inter-relate with one

[541] WHO.Doc.A65/24, 20Apr2012, p.134

[542] Chapter 2 establishes the responsibility to respect the right to health, justifying the duty not to violate the right to health and the duty to remediate such violation.

another, including governmental agencies, the researcher/innovators (i.e. pharmaceutical companies, and university laboratories), individual donors, as well as the global poor.

Moreover, the treaty proposes an open approach to intellectual property rights. In chapter 4, I discussed the purposes of intellectual property, and its justifications as a private property right: private property is a necessary legal institution for the common good of all. The exclusive property rights that certain individuals or groups have over certain resources is justified as mutually beneficial: first, the exclusivity is justified by the fact that a common resource administered by many tends to be neglected, disused, or inefficiently managed, and, second, the exclusivity is justified as it gives the private owner an incentive to foster his own productivity, creativity, and inventiveness, in a way that he can develop his private property to its full potential[543]. There are therefore good reasons to privatize properties, which originally pertained to the common stock and were therefore commonly available. Once they are made private, owners are entitled to private rights. Yet, these private property rights are not absolute, and thus certain limitations apply in certain cases (e.g. *superflua*, and catastrophe). As discussed in chapter 4, in these specific cases, the private property will lose its private feature, and become again, as a matter of justice, part of the common stock. The Medical R&D Treaty builds on this idea of a private property being made again public, and returning to the common stock, for the sake of the public interest.[544] Accordingly, the treaty adopts a

[543] Aquinas, Locke and Nozick agree on the reasonableness and mutual benefits of private property. Aquinas, *ST* ii-ii, q66,a2; Locke, *Two Treatises of Government – Book I*, para.86, Nozick, 1974, p.177

[544] This is the so-called open approach to intellectual property rights. Risse's theory on the Global Commons and an Intellectual Common presents the most complete argument for the open approach for intellectual property rights. Risse explains that Locke introduced the idea of the 'collective ownership of the earth', to then clarify how these collective goods could be legitimately privatized. Grocious builds on Locke's idea, emphasizing 'the good reasons for co-owners not to accept privatization of parts of the collectively owned earth (especially the seas)'. Risse's theory fully develops these ideas, and applies then in relation to

distinct framework that justifies the sharing of knowledge and scientific progress as a communal good, trusting that this communal sharing would 'enhance the transfer of and building of technological knowledge and R&D capacity to further social and economic welfare and development in developing countries'[545].

Although the Medical R&D Treaty proposes a systemic reform that is in principle aligned with GCJ, the treaty raises some concerns with regard to its effectiveness, since it is not clear how the open innovation approach would provide an adequate alternative to incentivize and recompense R&D, overcoming these common problems of inefficient management of communal shared properties. It is also not clear how the treaty's open innovation approach to intellectual property rights would in actuality incentivize, and build the global common good up continually. Given that the existing TRIPs regime is solely based on the opposite approach of intellectual enclosure, the treaty raises some concerns with regard to its political feasibility. It could be argued the systemic reform proposed by the treaty is too drastic in reference to the status quo, and therefore an intermediate alternative would be more prudent, at least as an intermediate step towards a fully opened approach of R&D for neglected diseases. The HIF would be an example of such intermediate degree. The HIF, as we shall see below, would be somewhere in between the two extremes of open innovation to intellectual property rights, on the one hand, and the TRIP's intellectual enclosure, on the other. This thesis does not answer the policy question of which of these measures is the most effective. It only attempts to provide a framework for the moral evaluation of these policies and of the duties they

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intellectual property rights. His is based on this Grotian account. (Risse, 'Is there a human right to essential pharmaceuticals? – The Global Common, the IntellectualCommon, and the Possibility of Private Intellectual Property', in Millum and Emanuel, *Global Justice and Bioethics*, OUP, 2012, pp.43-77, p.46)

[545] WHO.Doc.A65/24, 20Apr2012, p.134

impose on states and non-state players, particularly pharmaceutical companies. However, since the HIF seems to me to be the most promising measure (from a policy perspective), I will illustrate the application of the framework in greater detail by applying it to the HIF.

5.2.4. The Health Impact Fund – HIF Proposal

The HIF aims to correct the existing market failure related to the neglected diseases dual problem (which defines the GHC); it incentivizes R&D on neglected diseases by rewarding the innovator in proportion to the health impact of his innovation. In order to understand the HIF's mechanism, let us recapitulate briefly how the existing TRIPs regime operates. The existing system encourages R&D by promising high financial returns to the innovator through the patents. Patents therefore stimulate the practice of exorbitant drug prices, and this negatively impacts the right to health of many people, especially those with reduced purchasing power. It also focuses R&D on those populations that can afford medicine—that of wealthier countries. The HIF aims to correct the market failures that generate such right to health deficits, without overlooking the need to encourage scientific innovation, and to reward research justly.

The HIF is conceived as a global fund, to be established by a binding international treaty, and to be financed by member-states, seeking to foster not only R&D of medical technologies, but also the adequate distribution of affordable medicines[546]. Under the HIF proposal, any pharmaceutical innovator would be eligible for rewards proportional to

[546] The HIF would therefore offer an alternative not only to the problems of lack of access to medical knowledge, and lack of access to affordable medicine, but also an incentive to tackle the last-mile problem as well, in order to enhance the 'health impact' of a certain medicine. For the definition of each of these three problems, see the introduction of the thesis.

the impact of its invention on the health of the population (the poorer the population, the greater the impact of an innovation). The HIF would give the owners of pharmaceutical innovations (such as pharmaceutical companies, university laboratories, governmental agencies, etc) an option: the innovator has the choice of either patenting its innovation in the usual way (i.e. under the TRIPs rationale), or registering its innovation with the HIF. Under the HIF proposal, innovators are therefore free to take out patents on their innovation – but they would also be free not to do so (i.e. to simply register their innovation with the HIF, and then to collect the health impact rewards for the first 10 years that the product is on the market). Registration with the HIF would be especially advantageous and profitable for owners of pharmaceutical innovations that highly impact public health but do not sell well at high prices. This is precisely the case of medicines for neglected diseases, that is, serious diseases with high levels of morbidity that predominantly affect poor people with little or no purchase power.

Under the HIF model, owners of pharmaceutical innovations contractually accept the legal obligation to sell the registered medicine to wholesalers at the lowest feasible cost of manufacture and distribution as determined, typically, by a tender (where competing reliable manufacturers bid for the contract to produce the medicine on behalf of the innovator). There is an incentive to lower the price even further, because then, by expanding people's access to the treatment, its positive impact on public health is increased, and thus the greater will be the reward to be received. The larger the number of beneficiaries - especially those who would never otherwise have access to that particular medical treatment - the greater the positive health impact that a given drug produces, and therefore the greater the reward that the HIF would pay to its innovator.

Similar to the Medical R&D Treaty, the HIF also combines the strengths of both push and pull mechanisms: member-states would provide a sustainable and long-term source of public funding for R&D on neglected diseases (push component), and it pays only for performance (pull component). Similar to the Medical R&D Treaty, the HIF is also designed to be an institution to be settled by a binding international treaty. Moreover, the HIF, just like the Medical R&D Treaty, also proposes a reform of the current TRIPs regime, aiming to tackle the dual problem of the GHC (i.e. lack of access to medical knowledge, and lack of access to medicines).

Nevertheless, the HIF is different from the Medical R&D Treaty in fundamental aspects: the HIF proposes a different rationale in order to avert the Medical R&D Treaty's main downside. As Pogge explains, in the Medical R&D Treaty proposal, it is the committee of representatives from the member-states that defines the research agenda and the funding allocation; therefore the research grants become contingent upon the changing political priorities and good will of the committee representatives. He writes:

> One significant concern about this treaty is that its terms allow too much flexibility in funding allocations. Such flexibility would enable governments to make resource allocations based on domestic political interests, rather than global health needs.[547]

So, under the HIF proposal, it is not a committee that defines the research agenda, but the researchers themselves -- maintaining therefore the same rationale of the current TRIPs regime, where it is the researcher who autonomously decides on what to pursue

[547] Hollis, Pogge, 2008, p.104

his research. So, under the TRIPs, the prospect of the profits the researcher can make by selling the innovation at the highest price possible is the incentive he has to pursue his research project. Likewise, under the HIF proposal, it is also the researcher who autonomously decides on what to pursue research. Yet, his incentives do not lie on the consumers' ability to pay for his innovation, but rather on the 'health impact'[548] of his discovery: the greater the health impact of the innovation, the greater the innovator's rewards.

This is the essential difference between the Medical R&D Treaty and the HIF. The former incentivizes R&D on neglected diseases by freely sharing of the outcome of R&D via an open innovation approach to intellectual property – which means no patent protection or exclusive rights for innovators at all, and openly, freely and publically shared research outcomes[549]. The HIF, on the other hand, incentivizes R&D on neglected diseases by rewarding the innovator with recompense, proportionate to the health impact of his innovation. The HIF allows, then, to an extent, the maintenance of certain exclusive rights to the innovator, although not as extensive as in the current TRIPs regime, as we will see below.

Both the Medical R&D Treaty and the HIF are institutional alternatives to the existing TRIPs regime: both aim to tackle the neglected diseases dual problem, which is a result of a market failure within the existing TRIPs system. Each institutional reform proposal presents, nevertheless, a different institutional framework to tackle these two problems.

[548] 'Health impact' is a complex and highly technical concept of health care economics, based on specific measurement indicators. For a detailed explanation on how the impact is measured, see Hollis, Pogge, 2008, ch.3

[549] Ibid, pp. 33, 103, 171

The Medical R&D Treaty proposes an institutional approach that is radically opposed to the existing TRIPs regime: while the Medical R&D Treaty is based on the 'open innovation' approach to intellectual property, where R&D generates knowledge that is free to be used without legal restrictions, the current TRIPs regime is solely based on intellectual enclosure, allowing the discovery to be kept in secret, under the monopoly protection of the patent. The HIF, by its turn, proposes a less radical alteration of the current TRIPs regime: the HIF would leave the TRIPs regime aside as it is, but correct its failures through a complementing alternative, which has the same rational (i.e. incentive and recompense) of the existing TRIPs. The TRIPs' alternative is less radical in the sense that it allows certain monopoly rights for the researcher/innovator. The HIF gives researchers/innovators the option of either taking out patents on their innovations, or registering their innovation with the HIF, and collecting health impact rewards for the first 10 years after entering into the market.

Although the WHO, the WIPO, and the WTO favor the open approach to intellectual property, and favor the Medical R&D Treaty's courageous alternative to the neglected diseases dual problem, they still have nevertheless evaluated the HIF as one of the most promising institutional proposals to date, given the robust moral appeal of the HIF. Their main critique of the HIF proposal has to do with the 'high costs and practical difficulties'[550] involved in the measurement of the 'health impact' of innovations.[551] These are technical aspects of health care economics, and they fall out of the scope of this thesis. For this reason they will not be considered in our moral evaluation of the HIF. Yet, the political feasibility of the HIF, combined with its completeness in tackling all

[550] WHO.Doc.A65/24, 20Apr2012, p.103

[551] Ibid, p.57

different aspects of the GHC (the dual problem of neglected diseases and beyond) provide strong reasons to defend the HIF as a sophisticated and a reasonable institutional reform alternative to the current TRIPs regime. Let us now assess the HIF, and explain its robust moral appeal. I am assessing the HIF in greater detail because the HIF seems to me to be the most promising (i.e. complete) measure from a policy perspective, and I will use the HIF as an example to show how the moral framework proposed by this thesis can be applied in detail. This does not suggest that the Medical R&D Treaty does not have a strong moral appeal either, or that the HIF is necessarily superior to the treaty at a policy level. The moral framework could also be applied to the treaty. Nevertheless, here I am applying the principles of justice that this thesis has been discussing specifically in the context of the HIF as a more precise illustration of the application of the moral framework developed up to this point.

5.3. A moral assessment of the HIF

How can the principles of justice discussed in the previous chapters of this thesis justify the HIF? The HIF tackles the dual problem of the GHC (defined in the introduction of the thesis), namely the problem of lack of access to medical knowledge, and the problem of lack of access to medicines. The HIF tackles the first problem of lack of access to medical knowledge by fostering research and innovation on neglected diseases; and it tackles the second problem of access to affordable medicine by encouraging the lowest possible prices for developed medicines addressing neglected diseases. In actuality, it has the potential to go even beyond that, and address the third and last-mile problem related to the distribution of medicine, as explained in the introduction of the thesis: researcher and innovators would have, under the HIF, the additional incentive to find

forms of distribution of affordable medicines, so to achieve an even higher health impact for their medicines, and thus get a higher reward.

The idea of the GCJ (defined in chapter 3) justifies the HIF in the same way that it justifies the Medical R&D Treaty: as discussed in chapter 2, given that the existing TRIPs structure imposes avoidable obstacles to the poor's secure access to their basic health needs, there is a breach of the responsibility to respect the human right to health. Consequently, the principles of GCJ justify the duty to remediate this violation that amounts to the GHC.

The HIF aims to rectify precisely this structural problem within the TRIPs, which I call the GHC, while at the same time building the global common good up by considering the rights and duties of different global players that inter-relate with one another, including governmental agencies, the researcher/innovators (i.e. pharmaceutical companies, and university laboratories), individual donors, as well as the global poor). As argued in chapter 4, pharmaceutical companies have a special responsibility in relation to neglected diseases, as owners of medical knowledge that is vital to remediate the GHC: they have the specific duty to disclose those specific patents that are vital to remediate the GHC. How does this specific duty apply to the HIF? It is a matter of complementarity. Pharmaceutical companies have a duty of justice to disclose certain patents, as argued in chapter 4. This is a duty that applies to existing medical patents – i.e. the medical knowledge and formulation already exist, and has to be now disclosed as a matter of justice. The HIF provides a framework for such disclosure by offering to the innovator the possibility of registration with the HIF. Additionally, the HIF also addresses the other failure of the TRIPs by providing a framework for incentivizing and recompensing new

medical knowledge and formulations specifically tailored for developing and under-developed countries.

The HIF proposes to remediate certain injustices within the TRIPs regime, entailing the GHC[552], while also harmonizing the rights and duties of all global players in relation to the rights of the global poor, and building the global common good up. The HIF aims therefore to discharge the duty to remediate the unjust side effects of the existing TRIPs regime, which GCJ requires. As a shared problem that justifies a shared solution, the GHC justifies a solution that refers back to the global common good of all stakeholders, including all relevant global players and the global poor. The HIF invites a responsible participation of all relevant stakeholders, including in particular those discussed in chapters 3 and 4, namely wealthy states, wealthy individuals, and pharmaceutical companies, while taking into consideration their fundamental rights to private property, as well as the fundamental right to health of the global poor.

The resources to sustain the HIF, crucially to pay innovators according to the health impact of their medical discovery would come primarily from wealthy states and wealthy individuals. But why should wealthy states and wealthy individuals provide the economic resources to sustain the HIF? There is certainly a reason of benevolence/charity to help the global poor. But in addition to that there is first and foremost a reason of justice. As discussed in chapter 2, whatever the duties imposed by the right to health, it is clear that it imposes at least a responsibility to respect the right. That right is violated when its

[552] As discussed in chapter 2, the current TRIPs regime has the side effect of producing certain injustices: the TRIPs imposed new laws in 1994 that introduced new institutional barriers against the poor's secure access to their basic health needs. As discussed in chapters 1 and 2, in the context of the GHC (i.e. neglected diseases dual problem), there is a (basic) right to health violation because there is an avoidable unsecure access to basic health needs.

enjoyment is made less secure. As argued in chapter 2, the enactment of the TRIPs regime had disastrous consequences for the right to health of an important part of the world population, exacerbating the GHC. As discussed in chapter 3, there is a reason of GCJ to remediate this exacerbation of the GHC. This responsibility to respect the common good (and thus respect the right to health) applies to all global players (as argued in chapter 2), but the duty to remediate breaches of the responsibilty to respect the right to health applies to those responsible for the breach as well as to those that participate in it in a different way, crucially by benefiting from such breach of the right to health. If my argument is correct, the duty to remediate for breaches of the responsibility to respect the right to health applies especially to wealthy states and wealthy individuals (as argued in chapter 3). Wealthy states and wealthy individuals ultimately share this responsibility to provide economic resources to sustain the HIF, as a way to remediate the GHC, precisely because they uphold and benefit from the current TRIPs regime. Since wealthy states and wealthy individuals shape the current regime, they have now, as argued in chapter 3, a duty of justice to reform it, precisely in those aspects where the TRIPs generates rights violations and injustices. These are strong reasons for supporting the HIF, precisely because the HIF allows states to discharge the duty to remediate the breach of the responsibility to respect the right to health. Such reasons not only justify HIF, but also are the kinds of reasons that are not subordinate to reasons for satisfying certain needs of nationals. As discussed in chapter 3, citizens' claims do not have priority over those claims supported by duties of justice against their states. In essence, there is a duty of wealthy states and wealthy individuals to provide the economic resources to sustain the HIF, as a specification of the duty to remediate and reform those global institutions that global players form and from which they benefit.

Conclusion

This chapter has discussed the main global health policies and practices addressing the GHC, and it has ordered them according to their foundational purposes: they have either a benevolence-based approach, or a justice-based approach. This distinction is relevant because their different purposes will yield different duties on the relevant agents. While principles of justice will yield enforceable duties, principles of benevolence will yield relevant yet non-enforceable humanitarian actions to help the poor. These two types of principles of practical reason are different, and they justify policies or institutions of different kinds. This chapter has shown which kinds of duties there are and what each type can or cannot justify.

The table below shows a summary of what policies and practices addressing the GHC have been discussed in this chapter, which concludes with a more detailed analysis of a promising and complete reform proposal: the HIF.

Policy		**Access to Medicine Problem Solving**	**Access to Medical Knowledge Problem Solving**
Benevolence-Based	Pharmacophilanthropy	√	No
	Differential pricing	√	No
	Voluntary licensing	√	No
	Bulk buying	√	No
Justice-Based	Publically Funded Research Grant*s*	Not entirely	√

	Product Development Partnerships	Not entirely	√
	Priority Review Vouchers	No	Not entirely
	Purchase or Procurement Agreements	Not entirely	Not entirely
	The proposed Medical R&D Treaty	√	√
	The proposed Health Impact Fund	√	√

Table 1: Global Health Institutions and Policies addressing the GHC

Conclusion

This thesis has provided a framework for analyzing the moral responsibilities of those global players related to the GHC. The main contribution of this thesis has been to provide a general account of the moral responsibilities of wealthy states, wealthy individuals, and pharmaceutical companies, mapping the different kinds of duties they have, their content and force, their relation to the responsibilities of other relevant players, and connecting this analysis with current debates on the duty to remediate the crisis by reforming certain international legal rules addressing the GHC (specifically TRIPs regime).

I have sustained the following argument: I start from the premise, widely accepted by participants in debates on the right to health, that Global Commutative Justice requires at least that all global players respect the basic human right to health of all persons. Given that some aspects of the current global economic order (crucially, the TRIPs regime) breach this responsibility to respect by systematically making less secure the access to basic health needs, I argue that there is a duty to remediate the violation of the basic human right to health perpetrated by those aspects of the current economic order. While all global players share certain responsibilities to remediate the negative effects of the GHC, different degrees of responsibility will apply to different global players, according to their relation to the GHC and to those afflicted by it. This thesis has emphasized the responsibilities of wealthy states and wealthy non-state actors who uphold and benefit from the current TRIPs regime, and it has also paid particular attention to the responsibilities of pharmaceutical companies. As private owners of relevant medical knowledge which is vital for the remediation of the crisis, these companies have certain responsibilities that are specific to them. Finally, this thesis also provides a discussion on how the duty to remediate the GHC can be implemented by different global players through institutional reforms of certain rules within the TRIPs regime.

The GHC exacerbates a severe deprivation of basic health needs. Chapter 1 differentiated basic and non-basic health needs, and concluded that this division is crucial, because the idea of basic health needs constitutes not only the object of the basic human rights to health (discussed in chapter 2), but also the object of justice

(Global Commutative Justice, to be precise) and its duties (discussed and specified in chapters 3, 4, and 5) in the context of the GHC. In doing so, this chapter challenges the mainstream well-being conception of the right to health, which conflates the categories of basic and non-basic health needs.

Chapter 2 built on the premises established in chapter 1, and explained the basic human right to health, and its correlated basic duties. The outcome of the chapter was to show a common ground understanding among policy makers and theorists on at least one type of responsibility: the negative responsibility to respect the right to health of others, meaning a negative responsibility to respect people's secure access to their basic health needs. The chapter has also detailed the specificities of the responsibility to respect, conceiving it as a two-fold responsibility, entailing (i) a duty not to infringe people's security of access to their basic health needs, and (ii) a duty to remediate such infringement. This chapter introduced and relied on a factual account of the impact of the TRIPs regime on the right to health. According to this account, the market failures within the TRIPs regime disrupt such security, and thereby inflict right-to-health violations through the exacerbation of the GHC. This justifies the duty to remediate, to be enforced upon all global players who uphold and benefit from the regime. The common ground responsibility to respect the right to health therefore justifies certain institutional reforms at the global level on certain aspects of the TRIPs rules, specifically where these rules generate injustices (i.e. right-to-health violations).

The reasons to remediate the GHC are grounded by both benevolence and justice, although each virtue will justify different policies requiring different actions from different global players. The difference between benevolence and justice is a crucial one, and it guided the discussions in chapters 3, 4, and 5.

Following the argument of chapter 2 on the responsibility to respect the right to health and the duty to remediate the GHC, chapter 3 showed when such remediation is justified by discussing six different scenarios of ill health and deprivation. The aim of this discussion was to show how state and non-state global players can be institutionally connected to the global poor and ill (irrespective of their citizenship), and thus why all global players can bear certain duties of justice (not only benevolence) to remediate the GHC. Chapter 3 therefore challenges the mainstream state-centered approach to public

international law, by justifying why all global players have certain duties of Global Commutative Justice towards the global poor afflicted by the GHC. The scenarios showed that certain global players are negligent about the negative impacts of the crisis, while benefiting from its structural causes. As such, they have a duty to remediate it, by reforming and reshaping the TRIPs system where it fails to incentivize R&D for neglected diseases.

Since the crux of the GHC, as defined in the introduction of the thesis, is a lack of medical innovation/R&D, comprising both the *research* (i.e. discovery) of medical knowledge, and the *development* of such medical knowledge into adequate medicines, the core of the duty to remediate the GHC is first and foremost a question of access to medical knowledge (i.e. scientific and technical medical progress indispensible to meet basic health needs). It is for this reason that chapter 4 further elaborated on the problem of access to medical knowledge as the root cause of the GHC. It was within this precise scope (namely access to medical knowledge) that chapter 4 concluded that specific duties of justice to remediate the GHC apply specifically to pharmaceutical firms, as private owners of relevant medical knowledge, vital to solve the GHC. As a matter of justice, and not only of benevolence, chapter 4 concluded that there is one specific restriction imposed on pharmaceutical firms' patent rights and relevant medical knowledge: pharmaceutical companies have a duty to publically disclose those medical patents (including substance and process -- i.e. the product as well as the R&D procedure and the stored medical research data used or unused by the company) that are vital to control or solve the GHC, for the limited period of time necessary for such remediation, and only to those afflicted populations (i.e. global poor affected by neglected diseases). This is such a stringent duty of justice that even the most libertarian theories, such as that of Robert Nozick (also discussed in chapter 4), would accept it.

Benevolence and justice warrant different forms of remediation. There is in actuality a plethora of proposals and policies to address the GHC, and chapter 5 analyzes them in light of the distinction between benevolence-based and justice-based policies and practices. While only principles of justice will yield enforceable duties, benevolence-based policies and practices cannot be enforced through the law; yet, the law can incentivize, coordinate and regulate these benevolent reasons for humanitarian aid, and indeed there are relevant and well-encompassing forms of humanitarian aid. Rather than

weighing the relative virtues of these benevolence-based policies in great detail, chapter 5 focused on justice-based policies, as the thesis was interested in those policies that can be allocated, specified and enforced through the law. Among the various justice-based policies and practices currently under debate, some are more complete than others in tackling all facets of the GHC. Chapter 5 identifies the HIF as the most promising (i.e. complete) measure from a policy perspective, tackling both the access to medical knowledge and access to developed medicine problems, as well as the last-mile problem. Thus, the HIF is assessed in greater detail and upheld as an example of how the moral claim of this thesis can be applied to morally evaluate concrete policy proposals.

In contemporary global culture, international organizations increasingly echo the assertion that all global players share responsibilities for the right to health of the poor. While various global players take this proclamation for granted, it has yet to produce a significant impact on the worsening GHC. This thesis has shown that, in order for effective change to take place, greater legal specificity has to exist regarding the responsibilities of certain parties: certain global players (particularly wealthy states, wealthy individuals, and pharmaceutical companies) share responsibilities of justice, and not only of benevolence towards the victims of neglected diseases. The framework provided by this thesis for analyzing the moral responsibilities of those global players related to the GHC can have, nevertheless, a broader implication: the general account of the moral responsibilities of wealthy states, wealthy individuals, and pharmaceutical companies, provided by this thesis, can also be applied to other global players related to the GHC, such as universities and research institutions, for example. Within the contextual pursuit of the remediation of the GHC, the responsibilities of academia and academics remain a prospect for further research. As global players who hold relevant medical knowledge, vital for making a significant, positive impact upon the GHC, these agents should also be subjected to certain enforceable moral responsibilities. Further research needs to be done successfully to quantify these responsibilities within a global culture which commodifies knowledge.

As an initial step towards remediating the GHC, this thesis has thus sought to present a crucial framework within which to identify and analyze the responsibilities of key global players in addressing this situation. It is hoped that the findings presented here will be

suitable for extended application not only within the specific context of the TRIPs regime, but also for other significant health policy concerns, and even more general situations where human rights violations are of concern.

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